



FINAL REPORT

IN FROM THE STREETS: THE HEALTH AND WELL BEING OF FORMERLY HOMELESS OLDER ADULTS

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EXECUTIVE SUMMARY

Study Context and Objectives

This study explores the impact of housing on the health and well-being of formerly homeless older adults. The study was informed by several theoretical frameworks:

- the “causes” of homelessness are the result of the interaction and overlap of both structural and individual factors;
- an understanding of the social determinants of health provides a powerful conceptual tool for understanding how homelessness and housing impacts health;
- a social inclusion framework extends the scope of the study to include quality of life, social capital, belonging and social connections, participation, employment, civic engagement, and discrimination; and
- a human rights framework that maintains that housing is a right, as outlined in the Universal Declaration of Human Rights Article 25 (1948).

The primary research question was formulated to ask, what are the health and housing outcomes for formerly homeless older adults? Seven key objectives were identified to answer the research question. The study objectives are:

1. To better understand the characteristics and socio-economic status of older people who were once homeless;
2. To examine the extent to which older homeless people are recovering from health consequences once they are housed;
3. To identify the service, support, and housing needs of formerly homeless older adults, and the barriers and successes in current practice;
4. To determine the effective recovery supports/services/programs;
5. To describe the models that allow these programs to be effective;
6. To clarify the limitations of these models for older adults; and
7. To articulate policy, funding and program implications for government, service providers, and other community stakeholders.



Methodology

Data to evaluate health and housing outcomes was drawn from a non-random sample of formerly homeless older adults (50 years of age and older) living in supportive (housing with onsite supports) and supported housing (housing with de-linked community supports) in Toronto, Ontario and Calgary, Alberta. A mixed-method approach was employed with data collected from 237 face-to-face quantitative interviews (Toronto, n = 201; Calgary, n = 36¹), 53 qualitative interviews (Toronto, n = 35; Calgary, n = 18) and 6 focus groups (69 participants total: Toronto, n = 33; Calgary, n = 37). Other sources of data included a literature review and the personal health information² (PHI) of the consenting Ontario participants. The PHI data was used to track utilization of health care services before and after becoming housed. Data emerging from a comprehensive literature review informed the content of the data collection tools and provided context for the findings.

Data was analysed using both quantitative and qualitative strategies within a concurrent triangulation model. Descriptive statistics were used to analyse data from the survey and from the PHI. The transcripts from the qualitative interviews and focus groups were coded, organized into emergent categories and then clustered according to central themes. Finally those themes were interpreted and a qualitative narrative, embedded with representative quotes, was produced.

Supplementary funding was secured to develop a working group of research participants tasked with creative dissemination. The dissemination focused on two primary actions: a postcard campaign and a speakers' bureau. The group developed an innovative research poster using paint and collage, which was displayed at a number of forums. This poster was scaled down to a postcard messaging key actions that emerged from the study. The working group coordinated outreach to the community to solicit signatures and the signed postcards will be mailed and delivered to relevant policy makers.

Key Findings

Quantitative Survey Key Findings

- Of the 237 participants who responded to the survey in Toronto and Calgary, the majority were male, which accurately reflects the proportion of men to women in the

¹ Recruitment challenges resulted in a lower number of survey interviews in Calgary than initially targeted.

² Initially the PHI of Calgary participants was to be analysed. However, only 28 participants consented to release of the PHI, a sample too small to conduct a meaningful analysis.



homeless population. The average age was 57 in both samples, an age both groups considered to be “old.” Most of the participants were born in Canada and identified as ‘white,’ although Toronto had a larger percentage of immigrants and Calgary had a higher percentage of Aboriginal peoples. Most were unattached in terms of marital status and were mainly single or divorced, and over half in both samples had attended or completed high school.

- Over 60 percent of the participants in Toronto and 56 percent of the formerly homeless participants in Calgary had been homeless more than once, with men reporting significantly more homeless episodes than women in both cities.
- In Toronto, 71 percent lived in supportive housing compared to 42 percent in Calgary and the remainder lived in independent housing with the help of community supports.
- In Toronto, about 50 percent had been housed for over five years compared to only eight percent for Calgary.
- The last episode of homelessness in Calgary was much shorter than for Toronto, suggesting a quicker turn around in interventions that provided support and housing.
- About one-half of the participants in both cities had found their housing with help from a professional service worker. The other half relied on word of mouth and informal networks indicating that this informal system is an important mechanism for communication.
- Overall the health and well-being of formerly homeless older adults improved relative to health indicators for homeless older adults in previous research, but were lower than similar indicators reported for the general population. The Calgary sample reported poorer physical health than the Toronto group but better mental health.
- In 6 months prior to the survey, two-thirds of Toronto participants reported receiving care from a private doctor, while slightly less than 50 percent saw a private doctor in Calgary. The percentage of emergency visits was almost identical for both groups but Calgarians were more likely to be hospitalized (33 percent vs. 23 percent). A larger proportion of Calgary respondents used walk-in clinics and community health centres (CHC).
- The findings from a pre to post housing analysis of health care utilization data in Toronto indicated that there was no significant change from pre-test to post-test for fee-for-service, but there was a significant decrease in the mean days of emergency room use, and the mean days used for in-patient/day patient care.
- The scores on the measures of social isolation and networks for both the Toronto and Calgary respondents indicated that formerly homeless participants were at considerable risk of social isolation and relied heavily on service providers for support.



- Little more than one-quarter of the participants reported any income from employment in the previous six months. The majority of participants reported a yearly income for 2004 in the range of \$10,000 to \$11,999, well below the current Low Income Cut-Off for individuals. Notably, a high proportion of participants relied on food banks and meal programs.

Qualitative Interview Key Findings

- Participants reported lingering “homeless effects,” such as feelings of trauma and mistrust, that impacted their psycho-social health and well-being, and many mentioned that recovery was an ongoing process.
- While health status and well-being varied across participants, most participants acknowledged that securing housing was the critical first step toward improved health and wellness.
- Participants emphasized that housing ends “houselessness,” but much more is needed to support health, wellness and social inclusion.
- Participants are struggling to find “home” in their housing, their communities and in the broader society.
- Participants did not perceive themselves as “settled” or “retired” or “old.” “Transitioning” emerged as a theme in many different areas: transitioning from housing to “home;” transitioning toward health, wellness and social inclusion; and transitioning out of poverty.
- Significant barriers limited participants’ ability to transition, such as limited age-appropriate, affordable housing and support options; persistent “homeless effects” and accelerated “aging effects;” “poverty or welfare walls” imposed by inadequate income and employment supports; and ageism, particularly the special class of ageism identified as the “gap” (the 50-65 demographic falling between general population and senior services).

Focus Group Key Findings

- More affordable and age-appropriate rental housing is needed that includes a broad menu of housing and support options situated in mixed housing sites with market rent and rent geared to income (RGI) units.



- Enhanced funding is required to ensure that supports are accessible to everyone, particularly in the areas of life skills, therapeutic, personal support and housekeeping services.
- Integrated service delivery (e.g., coordinated mental health, health and personal care), policy frameworks, and funding mechanisms are necessary to ensure seamless and coordinated housing and supports to health and well-being of formerly homeless older adults.
- Networks of support must extend to and institutionalize partnerships with off-site agencies, informal community networks, peer support programs and families.
- Training, education and other employment supports, as well as volunteer opportunities, based on long-term commitment and investment in people's capacity are necessary to ensure that formerly homeless older adults are meaningfully engaged and valued.
- The current service paradigm does not represent a “goodness of fit” with the service delivery needs of formerly homeless older adults (i.e., currently waiting days or months to see a service provider). Service delivery must shift to reflect the realities of these individuals' lives.
- There is a need for more housing professionals; staff who are knowledgeable about the range of programs, services and housing options available to formerly homeless older adults and whose time may be solely dedicated to serving this population.

Overall Significance of the Findings to Practice, Program and Policy Development

- Health, support and housing programs should be sensitive to “homeless effects” and accelerated “aging effects” by recognizing and supporting recovery from these effects to prevent formerly homeless older adults from cycling back to homelessness. Rapid intervention is crucial. Support must travel with people as they transition and is particularly critical during the first years of housing.
- Developing and evaluating age-appropriate affordable housing and supports are of primary importance. However, development of housing and supports must consider social inclusion so that community integration, belonging, participation, overcoming discrimination and stigma, and other measures of quality of life can also be addressed.
- Assumptions around income support and employment support for this group need to be revisited. There is a significant disconnect between expectations embedded in these programs and the severe barriers experienced by formerly homeless older adults.



- Homelessness and former homelessness should be situated within the broader context of poverty so that they are not treated as discrete nor disconnected from issues impacting other socio-economically marginalized groups.

Recommendations

Policy Recommendations

1. Develop more permanent, age-appropriate, and affordable rental housing.
Federal: Develop a national housing policy; renew and expand the National Homelessness Initiative's (NHI) Supporting Community Partnership Initiative (SCPI).
Provincial: Address the significant shortfall in the number of affordable housing units promised in the Affordable Housing Agreement Framework; expand Housing Allowance programs and sanction municipalities to use shelter per diems.
Municipal: Expand private sector partnering in the development of social housing; Ensure that municipal planning and zoning by-laws protect existing and promote new development of affordable rental housing stock.
2. Develop more supports for older adults to "age in place" and to promote health and well-being.
Federal: Evaluate the need for a clearer policy framework to prevent "undue institutionalization" and to promote community-based care.
Provincial: Recognize that housing and community-based supports contribute to the sustainability of the health care system and may moderate demand on more costly acute and institutional care.
3. Increase income support for older adults.
Federal: Re-establish federal standards for income assistance.
Provincial: Reform income support programs and raise minimum wage to reflect the real cost of living.
Municipal: Ensure that administration of income support and application processes are accessible, transparent and timely.
4. Housing ends 'houselessness,' but much more is needed to foster social inclusion for older adults who have been homeless.
Federal: Government leadership at all levels is crucial to eliminate discriminatory practices, policies and terminology against formerly homeless older adults, and other marginalized groups.
Provincial: Expand and enhance employment support programs to ensure that individual capacity is considered and supported.



Municipal: Foster, support, and value long term volunteerism; fund and support peer programs and resources that incorporate and value the lived experience of homeless and formerly homeless older adults.

Program Recommendations

1. Incorporate generic guiding principles into the development of models of service delivery.
2. Design new housing that accommodates the needs of older homeless adults to make “aging in place” possible.
3. Enhance mental health and addiction services.
4. Create flexibility in housing and service delivery.
5. Make more use of case management services.
6. Programming should address the “age-gap.”
7. Programming must include attention to transportation systems.
8. Programming should monitoring financial abuse.
9. Early intervention to prevent eviction is required.
10. Provide education for service providers about “accelerated aging effects” and “homeless effects” to counter discrimination.
11. Programming must use and value peer resources.
12. Enhance public awareness of homelessness and aging.



ABSTRACT - ENGLISH

In from the streets: The health and well-being of formerly homeless older adults'

Despite the increased focus on the homeless population in Canada, there is little empirical knowledge about the characteristics, circumstances, health, housing and service needs of older homeless adults, especially after they have been housed. As the number of homeless older adults is expected to increase with the aging of the baby boomers, improving service delivery to reach this population is important. While the experience of homelessness impacts the health and well-being of older adults, aging adds a new dimension creating unique challenges for programming, policy and service provision. This two city study: Toronto and Calgary, employed a mixed-method approach drawing on data from 236 survey interviews, 53 qualitative interviews, six focus groups and the Personal Health Information from consenting participants to investigate the health and housing outcomes of formerly homeless older adult. Further, supplementary funding was secured to develop a working group of research participants tasked with creative dissemination. The dissemination was carried out through two primary actions: a postcard campaign and a speakers' bureau.

Findings suggest that housing is a critical determinant of health and that health care utilization post housing is associated with improved health outcomes and more effective and cost efficient use of health care services. Further, housing outcomes evidence that this population can be appropriately and stably housed within a number of variants of the housing support matrix. Evidence based recommendations for policy, programming and practice in the area of housing and health services suggest that investment in age-appropriate, affordable, housing and supports is key to formerly homeless older adults finding their way "in from the streets."



ABSTRACT - FRANÇAIS

Résumé du rapport de recherche intitulé

« **In from the streets: The health and well-being of formerly homeless older adults** »

Malgré l'attention accrue dont fait l'objet la population des sans-abri du Canada, on possède très peu de connaissances empiriques sur les caractéristiques, les circonstances, la santé, le logement et les besoins en services des itinérants adultes plus âgés, particulièrement après qu'ils aient emménagé dans un logement. Étant donné que les itinérants plus âgés devraient augmenter en nombre avec le vieillissement de la génération du baby-boom, il est important d'améliorer la prestation des services pour joindre cette population. Vivre l'itinérance produit un effet sur la santé et le bien-être des adultes plus âgés, mais le vieillissement y ajoute une nouvelle dimension qui donne lieu à des difficultés uniques, en termes de création de programmes, d'élaboration de lignes de conduite et de prestation de services. Cette étude, qui porte sur deux villes, Toronto et Calgary, s'est appuyée sur une démarche combinant diverses méthodes pour recueillir des données et creuser les effets sur la santé et le logement qu'ont ressentis des adultes plus âgés ayant vécu l'itinérance. De plus, on a obtenu des fonds supplémentaires pour la création d'un groupe de travail constitué de participants qu'on a chargés d'explorer des modes de diffusion créatifs. La diffusion de l'information s'est principalement faite de deux façons : une campagne de cartes postales et un bureau des conférenciers.

Selon les constatations, le logement serait un facteur déterminant essentiel sur le plan de la santé, et l'utilisation des soins de santé après l'emménagement dans un logement serait liée à une amélioration de l'état de santé et à une utilisation plus efficace et efficiente des soins de santé. De plus, les résultats obtenus en ce qui concerne le logement démontrent que les membres de ce segment de la population peuvent avoir des logements convenables et stables, compte tenu d'un certain nombre de variantes de la matrice de l'aide au logement. Selon les recommandations qui s'appuient sur les faits constatés, il est essentiel d'investir dans des logements et des services de soutien abordables et axés sur l'âge de la clientèle pour que les itinérants plus âgés arrivent à quitter la rue.



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We also wish to thank the Health Data and Decision Support Unit (HDDSU) of the Ministry of Health and Long-Term Care (MOHLTC) for the release of Personal Health Information (PHI) data, and for their support during the secondary data analysis. This study reflects the research and recommendations of the authors and not those of the HDDSU of the MOHLTC.

Finally, we wish to thank and acknowledge our funder. This report was prepared for the National Secretariat on Homelessness and received funding from the National Research Program of the National Homelessness Initiative (NHI). We also wish it to be known that the research and recommendations herein are those of the authors of this report and do not necessarily reflect the views of the National Secretariat on Homelessness.



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SECTION 1: INTRODUCTION

Project Description

Despite the increased focus on the homeless population in Canada, there is little empirical knowledge about the characteristics, circumstances, health, housing, and service needs of older homeless adults, especially after they have been housed. As the number of homeless older adults is expected to increase with the aging of the baby boomers (British Columbia Ministry of Social Development and Economic Security, 2001; Crane & Warnes, 2001; Doolin, 1986; Hecht & Coyle, 2001; Keigher & Greenblatt, 1992; Rosenheck, Bassuk & Salomon, 1999; Tully & Jacobson, 1994), improving service delivery to reach this population is important. While the experience of homelessness impacts the health and well-being of older adults, aging adds a new dimension (Crane & Warnes 2000; Cohen, 1999), creating unique challenges for programming, policy, and service provision. Additional information is required to develop effective strategies, housing, and supports which address both the experience of homelessness and aging.

The purpose of the study was to investigate the health and housing outcomes of formerly homeless older adults. The study was conducted between June 2005 and September 2006. The specific objectives of the study included a better understanding of the characteristics and socio-economic status of older people who were once homeless, the service and housing needs of formerly homeless older adults, the barriers and successes in current practice, the extent to which older homeless people are recovering from the health consequences of homelessness once they are housed, effective recovery supports/services/programs, the models that allow these programs to be effective, and the limitations of these models for older adults. Finally, these findings informed recommendations for policy, funding and programs provided by all three levels of government and community-based organizations.



Data to evaluate health and housing outcomes was drawn from a non-random sample of formerly homeless older adults (50 years of age and older) living in supportive and supported housing in Toronto, Ontario and Calgary, Alberta. A mixed-method approach was employed with data collected from 237 short face-to-face survey interviews (Toronto, n = 201; Calgary, n = 36³), 53 longer qualitative interviews (Toronto, n = 35; Calgary, n = 18) and 6 focus groups (69 participants total: Toronto, n = 32; Calgary, n = 37). Other sources of data included a literature review and the personal health information⁴ (PHI) of the consenting Ontario participants. The PHI data was used to track utilization of health care services before and after becoming housed. Data emerging from a comprehensive literature review informed the content of the data collection tools and provided context for the findings.

Data was analysed using both quantitative and qualitative strategies within a concurrent triangulation model. Descriptive statistics were used to analyse data from the survey and from the PHI. The transcripts from the qualitative interviews and focus groups were coded, organized into emergent categories, and then clustered according to central themes. Finally, those themes were interpreted and a qualitative narrative, with representative quotations, was produced.

Supplementary funding was secured to develop a working group of research participants tasked with creative dissemination. The dissemination focused on two primary actions: a postcard campaign and a speakers' bureau. The group developed an innovative research poster using paint and collage which was displayed at a number of forums, including working group speaking engagements. This poster was scaled down to a postcard which messaged key actions emerging from the study. The working group coordinated outreach to the community to solicit signatures and the signed postcards will be sent to relevant policy makers.

³ Recruitment challenges resulted in a lower number of survey interviews in Calgary than initially targeted.

⁴ Initially the PHI of Calgary participants was to be analysed. However, only 28 participants consented to release of the PHI, a sample too small to conduct a meaningful analysis.



Context of the Study

The question of what happens to formerly homeless older adults once they are housed was situated within several frameworks: that homelessness and staying housed involves a complex interaction of structural factors and individual vulnerabilities, that housing is a social determinant of health, that housing is a human right and that housing is a lever for social inclusion.

Frequently, the debate about the causes of homelessness is framed in such a way that individual and structural factors are dichotomized. However, a substantial body of literature (Susser, Moore, & Link, 1993; Cohen, 1999; Crane & Warnes, 2001, Crane, Byrne, & Fu et al. 2005), and this study, recognize the interaction and overlap of both factors as they impact pathways into homelessness, pathways into housing, and housing stability over time.

The framework of the social determinants of health provides a powerful conceptual tool for understanding how homelessness and housing impacts health. Dunn (2003) explains that social determinants of health emerged to address the strong relationship, observed for over a century, between an individual's socio-economic status and his or her health status. If, as Dunn suggests, systematic differences in health are linked to the quality and stresses of life, then housing is one way to understand how those conditions impact health.

Explanations of the pathways by which housing affects health and mechanisms to address health inequalities remain elusive. In a systematic review of interventions to improve the health of the homeless, Hwang, Tolomoczenko, Kouyoumdjian and Garner (2005) concluded that examining the impact of housing on health was limited by methodological and ethical issues, such as the impossibility of random sampling and the lack of clear articulation of the housing models. Despite these challenges to the framework, it remains a useful context for understanding how supportive and supported housing impacts the health and well-being of formerly homeless older adults. However, as Dunn (2002) and others have cautioned, the



framework should be set within the argument that housing is an entitlement that may make a difference to measurable health outcomes.

Consequently, this study recognizes that housing is a right as outlined in the United Nations Universal Declaration of Human Rights (1948) and that homelessness is not a trait, but a condition (Springer, 2000). Springer (2000) contends there are significant semantic and methodological issues with the term “homelessness” and has proposed “houselessness” as an alternative. This distinction also has merit in that it clarifies that housing ends “houselessness” but that finding a “home” involves the broader issue of social inclusion.

Framing the understanding of the health and well-being of formerly homeless older adults in the context of social inclusion extends the scope of the study to questions of quality of life, social capital, belonging and social connections, participation, employment, civic engagement, and discrimination. Social inclusion is a concept linked to the term “social exclusion” that was used in a social policy context in the European Union, especially the UK, during an anti-poverty campaign focusing on the integration of the “least privileged” (Pawson & Kintrea, 2002). Although the term is contested, the authors suggest that it evolved as a concept to integrate “relational issues” (e.g., inadequate social participation, lack of social integration, and lack of power) with “distributional issues” (e.g. inadequate income and other resources). However, the term “social exclusion” soon became paired primarily with income and employment. Later, usage of term “social inclusion” was adopted to not only stress the positive outcome rather than the negative barrier but also to re-emphasize the relational issues of engagement and integration.

As Arthurson (2004) highlights, housing can be a lever for social inclusion or exclusion. Consequently, a social inclusion framework is a useful tool for capturing the full complexity of challenges confronting formerly homeless older adults. Further, social inclusion locates the issue of securing affordable, age-appropriate housing and supports for formerly homeless older adults as a societal concern and in the broader context of building health communities.



Organization of the Report

Section One of this report concludes with a comprehensive literature review to provide background and contextualize the findings that follow. Section Two outlines the methodology used in the study, including the sampling strategy, the instruments used for data collection, and a description of the data analyses. Section Three presents the results of the analyses from the four sources of data collected. Although the data was collected in Toronto and Calgary, the results of analysis for each of the data sources integrate the findings from both cities⁵, while highlighting important differences. Section Four triangulates the results of the four analyses as they relate to the research question and objectives. Section Four also discusses the potential significance of the findings and the multiple linkages to the homeless community that were made during the course of the research. Section Five outlines specific recommendations for policy at all three levels of government, for programs and services and identifies areas for future research.

Literature Review

The following is a review of the scholarly and ‘grey’ literature about the older homeless and forms of alternative housing based on research in Canada, the United States and the United Kingdom. Research that considers older adults, homelessness, and the impact of alternative housing is, in fact, extremely rare and points to the importance of this research and the need for more knowledge in this area. This literature review considers research that is relevant to this study in three related areas: (1) homelessness in the general population and older homelessness, (2) alternative housing for the general population of homeless, and (3) alternative housing for older adults.

⁵Calgary is not integrated into one of the four data results, the secondary data analysis, as explained in footnote 2.



Defining the Problem: Homelessness and Elder Homelessness

The literature on homelessness reveals multiple ways in which homelessness is understood and defined. In some cases, “homelessness” is understood only as “absolute” or “literal” homeless; that is, those “living rough” on the streets. Other studies use a broader definition of homelessness to include shelter residents and those “at risk” for homelessness: people who are “doubling up” (living with others for free) and those who are temporarily or unstably housed, or otherwise “at risk” for homelessness. For our purposes, homelessness is broadly understood to include those who have lived “rough,” in shelters or in highly unstable housing.

Another term requiring definition is “old.” Studies on homelessness commonly use a lower threshold for defining adults as “old” because many homeless adults appear and behave 10 to 20 years older than the general population (Crane & Warnes 2000; Cohen, 1999) and their life expectancy is lower (Crane & Warnes, 2001). The research indicates that mortality rates are higher for older homeless adults and they are more likely to die from preventable diseases and accidental/unintentional injury (Ashe, Brandon, Contogouris, & Swanson, 1996; Barrow, Herman, Cordova, & Struening, 1999; Hibbs, Benne, Klugman, Spencer, Macchia, Mellinger et al., 1994; Hwang, Orav, O'Connell, Lebow, & Brennan, 1997; Hwang, 2000; Hwang, O'Connell, Lebow, Bierer, Orav, & Brennan, 2001.) Harsh living conditions exacerbate their acute and chronic health problems. Consequently, older homeless people often face greater health challenges and appear to be aging faster than persons of the same age living in stable housing. For example, in the USA, age-adjusted mortality rates among the homeless in a study in Philadelphia were 3.5 times that for Philadelphia's general population (Hibbs et al., 1994) and in New York, 4 times the rates of the general population (Barrow, Herman, Cordova, & Struening, 1999). In Toronto, mortality rates for men aged 45 to 64 were twice that for men in the general population (Hwang et al., 2001), a lower rate than that evidenced in the American studies and possibly linked to the lower incidence of homicide in Canada. These studies all support the conclusion that “one of the costs of being homeless in America is losing about 20 years of life expectancy” (Wright, Rubin, & Devine, 1998, p. 167).



As a result, some consensus has emerged within the literature that older homeless people should be defined as 50 years of age and older.

There is a small but growing body of research on older homeless adults that began in the mid-1980s, but literature on formerly homeless older adults is scant. The existing literature pays little attention to the heterogeneity of the homeless population, although there have been some attempts to distinguish the young from the older homeless (Gelberg, Linn, & Meyer-Oakes, 1990; Hallebone, 1997; Hecht & Coyle, 2001) and older homeless women from older homeless men (Cohen, Ramirez, Teresi, Gallagher & Sokolovsky, 1997; Kutza & Kreigher, 1991; Sterigiopoulos & Herrmann, 2003). A handful of scholars have acknowledged that, alongside the chronic older homeless, there are now older people who become homeless for the first time in old age (Cohen & Sokolovsky, 1989; Crane, 1994; O'Connell, Summerfield, & Kellogg, 1990; O'Reilly-Flemming, 1993).

Older homeless persons are of special concern because of their vulnerability to victimization, their frailty due to poor mental and physical health, and the reluctance of traditional aging services to incorporate them into their programs (Bottomley, Bissonette, & Snekvik, 2001; Kutza & Kiegher, 1991; Morbey, Pannell & Means, 2003; Roberstson & Greenblatt, 1992; Serge & Gnaedinger, 2003; Vermette, 1994). A report by the Canadian Mortgage and Housing Corporation (CMHC) noted that older people have longer stays in shelters compared to younger users, and suggested that the duration of homelessness for people over the age of 50 is linked to the lack of services for older homeless adults (Serge & Gnaedinger, 2003). Several scholars have also attributed longer lengths of stays to an absence of resettlement programs for older homeless people, and a failure of mainstream services to adequately address the needs of older homeless people (Crane & Warnes, 2001; Lipman, 1995).

Prevalence and Incidence Data

Due to the transient nature of the population, it has been difficult to obtain accurate prevalence and incidence data for older homeless adults. That is, for some people, there is continuous



movement between housed and homeless states, making it difficult to quantify the problem. This fact affects the precision of the statistics and counts of homelessness. As a result, the number of people who are homeless at a particular time is only a fraction of those who are ever homeless (Crane, 1996). Nevertheless, in the USA, the proportion of older persons in the homeless population has declined in past years, but the number of homeless adults aged 50 and over is increasing. This older population is likely to increase as the baby boomers age and the demand for affordable housing continues to rise (Robertson & Greenblatt, 1992).

With respect to prevalence data, for the most part, the literature reports small-scale surveys that are conducted either in specific cities, specific jurisdictions within a city, or specific programs or services. For example, a one-night survey was conducted in Boston, to determine the prevalence of older homeless people (Bissonnette & Hijjazi, 1994). On one night, 460 people aged 50 and over were found, which represented 24 percent of the total homeless population in 1992. One exception to these types of studies was a study conducted in 1990 in the USA that examined lifetime and five-year prevalence estimates of homelessness from 48 states (Link, Susser, Stuve, Phelan, Moore, & Struening, 1994). Random-digit dialing from a clustered stratified sampling approach was used to interview 1507 adults aged 18 and over. Those aged 55 and over made up over 300 (about 20 percent) of the sample, which is consistent with other reports. For the entire sample, the lifetime and 5-year prevalence rates for all types of homelessness were 14 percent (26 million people), and 4.6 percent (8.5 million people) respectively. The analyses, however, are not provided by age group (Link et al., 1994). Another large scale U.S. study involved interviews conducted with a random sample of approximately 4,200 clients in the homeless assistance programs in the USA (Burt, 1992). Among those that were currently homeless, 17 percent were 45 to 54 years old (11 percent female; 20 percent male), 6 percent were 55 to 64 (3 percent female, 8 percent male), and 2 percent were 65 and older (4 percent female; 1 percent male). Among those that were formerly homeless, 26 percent were aged 45 to 54, 11 percent were 55 to 64, 6 percent were 65 and older. Therefore, among the total users aged 45 and older, 25 percent were currently homeless; 43 percent were formerly homeless; and 46 percent were other service users. Of those aged 55



and older, 8 percent were homeless; 17 percent were formerly homeless; and 23 percent were other service users.

Although large scale studies have not been conducted in Canada, there are some Canadian data available that provide insight into this issue. A report published by the Canadian Mortgage and Housing Corporation in 2003 summarizes some of the existing data from studies conducted in Canadian cities on homelessness among older adults (Serge & Gnaedinger, 2003). Following is a brief overview of the findings reported in this review. A study conducted in Montreal and Quebec City that examined the use of shelters and day resources over a one-year period (1996-97) found that 35 percent of this population was over the age of 45 (Fournier, 1998). In the Greater Vancouver Area, a one-day count of the homeless population was performed in January 2002. This study found that 15 percent of the homeless population was between 45 and 54 years of age, and 5 percent was over 55 (Eberle Planning and Research, 2002). A one-day count of people living in shelters and other emergency accommodations in Edmonton, found 836 homeless persons, with 9 percent over the age of 55 (Edmonton Task Force on Homelessness, 1999). The report also noted an increase in the number of people over the age of 50 seeking use of a shelter in cities across the country (Serge & Gnaedinger, 2003). Utilizing 2001 Census data to assess shelter use across the country, the CMHC report states that slightly more than 14,000 people were found to be staying in shelters across Canada, with people aged 65 and over representing 10 percent of the total population (Statistics Canada, 2002). There is clearly some variation in the percentage of older homeless people among those that are homeless, partly due to the definition of "older" used in these studies, and the way the data are collected.

The Situation of Older Homeless Adults in Calgary and Toronto

The stereotype associated with homelessness—the image of a white older homeless man roaming the streets—is challenged by increasing evidence of homelessness among families, couples, youth, and women, and among persons who immigrate to Canada. Further, the majority of people experiencing homelessness are not constantly homeless as the



stereotype portrays; rather, their homelessness can be episodic in nature. They may move in and out of the state of homelessness. This poses a definite challenge for accurately determining the prevalence and incidence of homelessness, which remains a source of debate among researchers (Piliavin, Wright, Mare, & Westerfelt, 1996; Wong, Culhane, & Kuhn, 1997). There is little doubt, however, that the homeless population will increase as the baby boom generation ages, particularly if affordable housing continues to remain in short supply (British Columbia Ministry of Social Development and Economic Security, 2001; Crane & Warnes, 2001; Doolin, 1986; Hecht & Coyle, 2001; Keigher & Greenblatt, 1992; Rosenheck, Bassuk, & Salomon, 1999; Tully & Jacobson, 1994).

With regard to trends of increasing homelessness and older homelessness in the cities considered in this study, we have the following recent data. The 2006 Count of Homeless Persons by the City of Calgary (City of Calgary, 2006) found 3,436 homeless individuals in the city on May 10, 2006. The count was undertaken in facilities, where 82 percent of the homeless were enumerated, with 13 percent found in the streets and 5 percent in service agencies. The report states that the point-in-time count underestimates the numbers of homeless because it cannot account for the “hidden homeless” – those who were seeking shelter in abandoned buildings, “couch surfing,” or outside the geographical area of the count at that time. Of those counted, 1,593 (46 percent) were “working age adults,” age 25-44, 969 (28 percent) were “middle-aged adults,” age 45-64, and 106 (3 percent) were “seniors,” age 65 or older. The City of Calgary reports a 32 percent increase in the number of homeless persons since 2004, continuing a trend of increases of approximately 30 percent since the biennial count started 1994. The data does not show, regretfully, the percentage of change among the different age groups.

Toronto’s first homeless count occurred this year. The 2006 Street Needs Assessment (City of Toronto, 2006) estimated that there were 5,052 individuals homeless in Toronto on April 19, 2006. The total number was comprised of 3,649 (72 percent) known to be in shelters, 818 (16 percent) estimated to be on the street, 275 (5 percent) known to be in health care or treatment facilities, 171 (3 percent) known to be in Violence Against Women Shelters, and



139 (3 percent) known to be in correctional facilities. As with the Calgary count, the assessment was a “point-in-time” study, which excludes hidden homeless individuals, for example, “couch surfers.” Of those surveyed 13.4 percent were between the age of 51-60, 2.7 percent were between 61-65, and 1.6 percent were over 65 years of age. With the exception of the age group 61-65, the estimate found that the older a person is, the greater the number of years homeless, which is further evidence of the level of entrenchment experienced by older homeless adults.

While the Toronto count cannot yet confirm increasing homelessness, other analyses can. Local service providers estimated in 2003 that there were about 400 older people who were homeless in Toronto every night. They also reported an increase in the number of older homeless people in Toronto (Toronto Disaster Relief Committee, 2003). Over the last decade, the proportion of people aged 65 who access food banks across the Greater Toronto Area (GTA) has doubled. One in twenty people who rely on food banks is an older adult (Daily Bread Food Bank, 2001). Likewise, the number of older adults in the shelter system is also increasing. An analysis of the City of Toronto’s hostel data file during the fifteen-year period from 1987 to 2002 (McDonald, Dergal, & Cleghorn, 2004) provides some additional findings that are noteworthy. In this analysis, the “new” and “chronic” homeless are compared according to four age cohorts: 40-49, 50-59, 60-69 and 70 and over. Over the 15 year period there has been a rise in homeless single males, both new and chronic, the latter of which have risen dramatically in number. Most of the chronically homeless men are concentrated in the two youngest cohorts and are growing in size. There is a notable increase in the number of new homeless women in the 50-59 year cohort, and in the 70 and over category. The data also shows a downward spiral in the proportion of older people accessing subsidized housing, which highlights the housing shortage.

The shelter data from Toronto confirms that the numbers of homeless older adults are increasing. Although the proportion of older persons within the homeless population is low, the evidence shows that this proportion is disturbingly on the rise, as is the problem of homelessness itself.



Understanding Homelessness

The increasing prevalence and incidence of homelessness has researchers hypothesizing about root causes. Explanations focus on structural issues that are often beyond the control of the individual (Avramov, 1995; Greve, 1991; Wolch, Dear, & Akita, 1988) and personal vulnerabilities that jeopardize an individual's capacity to maintain stable housing (Hecht & Coyle, 2001). Usually both factors are seen to interact, pushing a person into homelessness, sometimes with a specific event acting as a trigger (Susser, Moore, & Link, 1993; Cohen, 1999; Crane & Warnes, 2001, Crane, Byrne, Fu, Lipmann et al. 2005). Some authors (e.g. Bottomley et al., 2001; Hallebone, 1997) favour structural factors such as the cutbacks in welfare payments, the shortage of government-subsidized rental housing and the decline in affordable housing as the main causes of homelessness amongst the young and the old. Hecht and Coyle (2001) and Hawes (1999) add that structural factors, particularly access to affordable housing, are exacerbated for people belonging to minority groups. Other authors (e.g. Rosenheck et al., 1999; Tully, 1994) cite the deinstitutionalization of mental health patients and their subsequent lack of both community mental health and economic supports as major structural factors leading to homelessness. Factors related to individual characteristics or behaviours such as alcohol and substance use problems, family breakdown, and health problems are examples of individual vulnerabilities associated with greater risk of homelessness (Wright, Rubin & Devine, 1998).

A model for homelessness and aging that combines structural and individual factors has been proposed by Cohen (1999) from the USA. The model suggests that risk factors for homelessness accumulate over a lifetime, and that homelessness is not likely to occur unless several risk factors co-exist. The model also recognizes gender differences, for example, that homelessness among women is more likely to stem from family crises (e.g. marital breakdown, widowhood), while among men, it is more often triggered by work-related challenges (e.g. loss of employment).



In a recent study of newly homeless older adults, Crane and colleagues (2005) found that service delivery failings on the part of the client or the agency were frequently implicated in pathways to homelessness, and that this factor had not been paid adequate attention in the research. The most common failure identified in the study was that a welfare benefit or service was not delivered to a client who was entitled to receive that benefit or service. Another pattern identified was that changes in an individual's record of rental payments precipitated eviction. Changes from regular to irregular rental payments were associated with major life events, such as the loss of a spouse or roommate or the onset of physical or mental illness. Consequently, the authors suggest that rental arrears should be seen as indicators of emergent service needs, which if addressed, may prevent eviction.

Revisiting Causation

Frequently, the debate about root causes frames the understanding of homelessness in such a way that the individual and socio-economic structures are dichotomized. Anucha (2005) presents an alternative framework for understanding homelessness that considers all of the factors that may interact to produce homelessness. This model was developed to illuminate episodic homelessness because, as the author argues elsewhere, episodic homelessness is the most prevalent form of homelessness (Anucha, 2003). Consequently, Anucha's model of the factors associated with the careers of episodically homeless persons is highly relevant to the homeless population at large. In this model, there are four factors that influence an individual's ability to remain housed or experience homelessness:

1. The Private Market Sector (housing and job realities): vacancy rate, cost of rental units, economic trends, availability of jobs;
2. The State: subsidized housing, affordable housing policies, income support programs;
3. Civil Society (non-profit sector, non-governmental organizations, social service agencies): resources in the community, community participation, social inclusion/exclusion, social capital;
4. Household or Individual Characteristics: socio-economic status, age, gender, ethnicity, "race" and migrant status, abilities/disabilities, housing preferences and satisfaction.



This model offers a useful framework for understanding the overlap and interaction of factors, and is useful to this review to help render the full complexity of homelessness, housing, and supports for formerly homeless older adults. Specifically, this review will first examine the matrix of housing and support options relevant to formerly homeless older adults, as well as the fiscal implications of the various housing and support interventions. This will be followed by an analysis of the multiple factors, both socio-economic and individual, that influence the health and well-being of formerly homeless older adults. These factors include income support; housing subsidies and employment; discrimination and stigma; physical and mental health needs and status, including substance use; gender differences; ethno-cultural diversity; different abilities; social capital; and social networks. The review will conclude with models of best practice in housing and health interventions for formerly homeless older adults that address housing security, aging and social inclusion. Finally, gaps in the research and future directions for research will be identified.

Defining a Solution

The Housing and Support Matrix

Alternative housing generally assumes two models: supportive and supported. Supportive units were the first to emerge and typically take the form of group homes or co-ops (CAMH, 2002) with supports linked to the facility and clients perceived of as “program participants.” The second model, supported housing, grew out of consumer demands for flexible and portable supports. Support services in this second model are de-linked from housing and are typically provided by community agencies.

Definitions

Definitions of alternative housing vary nationally and internationally and represent a continuum of housing models from independent units where a person may access supports in the community to high ratio, 24-hour staffed housing. Not only is there a broad spectrum of housing and support models but the terminology itself remains ambiguous. At times “supportive” means housing with linked onsite staffing, in contrast to “supported” housing,



which may include community based supports provided either on or off site (Hopper & Barrow, 2003; Rog, 2004; Tsemberis et al., 2000, 2004). At other times “supportive” and “supported” are used interchangeably (Clark & Rich, 2003; O’Malley & Croucher, 2005).

Further, in North America, the term “assisted living,” though previously used to describe supportive senior housing and, in some jurisdictions, to describe supports to developmentally and other differently abled persons, is now applied to supportive housing for other populations. Another emergent term is “supported living,” which again places emphasis on the client rather than the housing. The focus on “living” rather than the “housing” may diminish the definitional ambiguity of situating the supports.

Canadian definitions include those used by the Ontario Ministry of Health and Long-term Care (MOHLTC), which focuses on the 24-hour availability of personal care and homemaking services (2000). Alberta’s Housing Policy Framework (Province of Alberta, 2000) defines supportive housing as “housing largely occupied by tenants who require support services to live independently in the community, where providers may receive funding for support services from other sources”(p. 6) Many community-based groups prefer to highlight the nature of the services rather than the site of delivery, stressing that a person is supported through a comprehensive, coordinated and individualized package that is flexible to changing needs (The Toronto District Health Council, 2002; United Way, 2005). Both the Canada Mortgage and Housing Corporation (CMHC) and the National Advisory Council on Aging (NACA) define supportive housing as housing “that helps people in their daily living through the provision of a physical environment that is safe, secure, enabling and home-like and through the provision of support services that allow people to maximize their independence, privacy, decision-making and involvement, dignity and choices and preferences” (CMHC, 2000; NACA, 2002).

Below is a list of living arrangements typically associated with alternative housing. The selection is not exhaustive but provides a sample of the diversity of living arrangements available. It is loosely clustered under the categories of supportive or supported housing,



although, as previously mentioned, this distinction is highly contested. Tenants may receive rental subsidies directly in the form of rent-geared-to-income in social housing or indirectly through rent supplements to private landlords, or they may pay market rent. The following examples have been drawn from a number sources including CMHC (2000; 2005) and the Corporation for Supportive Housing (CSH, 2003), as well as the housing guides available from the Centre for Addictions and Mental Health (CAMH, 2006) and from Community Resource Connections of Toronto (CRCT, 2006).

Supportive Housing Models

Congregate Housing

Congregate housing originated in the USA. Tenants live in private self-contained units with some sort of staffing and services on site. Initially, this type of housing was built by private developers and targeted to higher income older adults. In the past two decades both not-for-profit and government-funded housing have adapted this framework for persons with various support needs and lower incomes.

Shared Housing

Shared housing, for example, Abbeyfield Homes, is usually renovated larger houses that accommodate ten or more older adults each with a separate lockable room and shared common space. This model is often adapted to high rise social housing sites where whole floors or portions of floors assume a similar configuration of private rooms set around common space.

Campus Model Housing

Campus model housing provides a continuum of care for tenants from independent apartments, to congregate supportive housing, to nursing home care in a single site allowing for fluid transitions and for partners with different needs to be accommodated. Co-locating a shelter, transitional and permanent supportive housing is a variation of this single-site continuum of care model.



Evolving Consumer Household

The “Evolving Consumer Household” model typically assumes a congregate or shared model that offers stepped supports, which, over time, assign greater responsibility to tenants while phasing out staff support (Goldfinger et al., 1999).

Domiciliary Hostels and Boarding Homes

Domiciliary hostels and boarding homes are chiefly for-profit, private residences typically subject to some government administration or regulation. Health and well-being supports are provided by outside agencies with on-site staff providing meal and housekeeping services.

Supported Housing Models

Supported housing can take the form of clustered single site shared or independent units or scattered site units. Units do not have onsite staff providing direct support but may have administrative staff that attend to tenancy issues and make referrals to off-site supports. Supported housing has evolved over the past few decades from a model situated at the end point of the linear residential continuum model to a point of entry. Typically, the linear residential continuum model presumes that tenants will progress through various levels of programs, housing and supports. For example, a person may have to achieve abstinence, medication compliance and have established treatment and therapeutic interventions prior to being offered permanent housing. Also, the housing and support package offered will depend on an assessment of the level of supports a person requires to achieve positive housing and health outcomes.

This model presumes that tenants must be “housing ready” and therefore may exclude individuals who are unable or unwilling to meet the criteria associated with various housing and support packages. Further, the model may demand several moves to sites with differing levels of support. Won & Solomon (2002) express concern that these moves may induce



housing instability. The authors suggest that the moves might result in a loss of social supports and possibly lead to grid-locking the system. The authors also question the assumption that a person will no longer need supports once they “graduate” to more independent housing.

In contrast to the linear residential continuum model with ‘supported’ housing at an endpoint are those models, sometimes referred to as “housing first,” which position “supported” housing as a point of entry to housing (Felton, 2003; Shinn et al., 2002). “Housing first” advocates endorse direct placement in supported housing with flexible supports and services that are responsive to the expressed needs of the consumer (Goldfinger et al, 1999; Rosenheck et al, 2003; Tsemberis & Eisenberg, 2000).

Comparisons of Housing Models

It is difficult to determine the relative efficacy of supportive and supported housing models. Although reviews of the literature (Fakhoury et al., 2002, Newman, 2001; Wong & Solomon, 2002) have found improved housing outcomes and less hospitalization for persons receiving immediate access to housing subsidies, evidence that differentiates between alternative housing models is less clear (Rog, 2004). Several studies have found differences in favour of “supported” housing (Goldfinger et al., 1999; Tsemberis & Eisenberg, 2000). Others, however, have found in favour of supportive housing (Culhane, Metraux, & Hadley, 2002; Bebout et al., 2001). The majority of studies found no significant differences across models (CMHS, 2002; Lipton et al., 2000; Rog et al., 2002). Non-significant findings for differences between housing interventions have been attributed to the blurring across models, the lack of fidelity to the practices embedded in the model and small sample sizes (Bebout et al., 2001; Rog, 2004).

Rog’s (2004) meta-analysis concluded that housing with supports, regardless of differences in the delivery of supports, has significant positive outcomes for housing stability and health outcomes. Although the implications for policy, funding and service delivery of different housing models are considerable, Hopper & Barrow (2003) cautioned that these differences should not obscure their substantial commonalities.



While challenging, the breadth of housing models and support packages that exist is an indication of innovation and sensitivity to the diversity of needs in the community. Most authors and advocates (Proscio, 2000; O'Malley & Croucher, 2005; Yanos et al., 2004) maintain that a singular model of housing and support would be neither desirable or appropriate and that a full continuum of housing and support options must be available to formerly homeless persons. The critical work of researchers, policy makers and housing and support providers is to identify mechanisms to ensure that the best “fit” is achieved between individual needs and preferences and the housing and support package.

Fiscal Implications: Cost Effectiveness Analysis

While the fit between the individual and the intervention is paramount, the costs associated with providing various housing and support packages merit consideration, especially in the current climate of fiscal constraint. The literature documenting the cost efficiencies associated with alternative housing has substantially increased in the last decade. Although there are many compelling reasons why immediate access to adequate and appropriate housing is a best practice for ending homelessness, research attesting to cost effectiveness remains contentious. The critiques of cost effectiveness analysis are largely based on fears that social policy grounded in economic analyses will reduce human social problems to dollars and potentially be used to justify further reductions in government spending on social programs. Others have countered that accountability for government spending and the apparent intractability of homelessness demand analysis of the real value of policy options both in terms of health and wellness outcomes and in terms of effectively targeted expenditures.

A recent Australian literature review provided robust evidence of quantifiable reductions in costs associated with hospitalization, use of emergency outpatient services, incarceration and use of emergency shelters once stable housing and appropriate supports were secured by homeless persons (Barry et al., 2003).



American studies investigating the social costs pre- and post-securing housing have found similarly favourable efficiencies. Culhane and colleagues (2002) examined service use data on 4,659 people placed in supportive housing between 1989 and 1997 and found a total reduction of 40 percent in the costs associated with shelter use, hospitalization and incarceration for formerly homeless living in supportive housing. Jones and colleagues (2003) conducted a cost-effectiveness analysis of a “critical time intervention.” Time limited support and service coordination to facilitate the transition into housing was compared to usual care, consisting of referrals to community-based programs with a 90 day window for contact (but not on-site visits) with shelter caseworkers. Costs estimated included acute care services, outpatient services, housing and shelter services, criminal justice services and transfer income (income support and housing subsidies). The authors found that although the costs associated with the two interventions were not significantly different, the amount of days homeless were significantly less for the “critical time intervention.”

The Corporation for Supportive Housing (Harder & Company Community Research, 2004; Proscio, 2005) conducted a similar analysis with residents from two sites: San Francisco and Alameda, California, from the much larger project, “Health, Housing and Integrated Services Network” (HHISN). The HHISN offers health care and other supports to well-being in conjunction with permanent, service-enriched housing for formerly homeless individuals suffering from mental illness, chronic health problems and/or substance use issues. The findings from the HHISN San Francisco site evaluations include a 56 percent decline in emergency room use, a 37 percent reduction in hospital inpatient days, a 89 percent decline in residential treatment days and a 44 percent reduction in days sentenced to incarceration. The second site, Alameda County, evidenced an 84 percent decline in day treatment days and a 48 percent decline in inpatient psychiatric days. Both reports conclude that the cost of “treating” long-term homelessness can be significantly reduced by coordinating housing, services, medical and psychiatric care, and addiction treatment in a carefully managed package.

Several Canadian researchers have conducted cost effectiveness analyses. Eberle and colleagues (2001) compared costs to health care, social service and criminal justice systems



associated with homelessness in British Columbia. Overall, the authors estimated a net savings of 30 percent could be attributed to the provision of stable housing. Gallant and colleagues (2004) evaluated the costs associated with “Tent City” Emergency Homelessness Pilot Project (EHPP), using data from the City of Toronto Hostel Services and a supportive housing provider. The authors found that housing costs were considerably lower than those for city-operated shelters and rooming houses. The cost of supports was estimated to be approximately half of equivalent supports offered in either a shelter or rooming house setting. Also, EHPP participants reported less emergency room visits and hospitalization than a comparable sample of homeless persons.

The most ambitious Canadian research to date conducted a detailed cost analysis of “alternate responses” to homelessness in four Canadian cities (Steve Pomeroy Focus Consulting Inc., 2005). The authors examined the relative costs of addressing homelessness through institutional and emergency responses as compared to community based supportive and affordable housing. They found that costs for the former were considerably greater than those for transitional, supportive or supported housing. Some highlights of the comparative costs of existing institutional and emergency responses to a matrix of housing and support options included institutional responses in the range of \$200 to \$600 per day, emergency response per diems in the range of \$25 to \$110 and transitional and supportive housing costs that ranged from \$3 to \$110 per day (the end of the range representing very high levels of supports; most of the costs from the four cities were in the range of \$20 to \$30). Not only were the cost efficiencies impressive for existing alternative housing settings but the authors also conducted a comprehensive forecast of costs for new developments. New alternative housing with supports was projected to cost in the range of 6 to 70 percent (depending on the levels of support) of the cost of institutional and emergency responses.

Although the research offers clear support for the cost effectiveness of investment in long term supportive options rather than emergency or crisis responses, it is limited by the diversity of models and of methodology evident in the literature. Also, as Pomeroy and colleagues (2004) caution, costs are highly dependent on individual factors and the various



options will not always be viable or long-term substitutes for each other. Consequently, future research should adopt a fine-grained analysis of realistic cost comparisons that recognize and accommodate the different clusters of needs and preferences evident in the homeless population.

The Health and Well-Being Matrix

Economic Insecurity

The literature on housing security tends to separate supply versus demand strategies for achieving affordable, appropriate housing. Supply side housing literature (Blasi, 1994; Marcuse, 1987) stresses housing supply and appropriate supports as critical to ending homelessness, while demand side literature highlights the role of inadequate income in barring access to adequate housing and supports (Drummond, 2004). The literature on income includes research that emphasizes the links to the labour force. Hopper (2003) suggests that casting homelessness in terms of demands for meaningful employment (rather than the demoralizing phenomenon of workfare) challenges a central stereotype associated with homelessness: that of “laziness” and of absence of a “proper work ethic” (Forte, 2002; Tipple & Speak, 2004). As Hopper (2003) and others caution, however, emphasis on employment risks marginalizing those who are unable to work.

Focusing on income prevents, what Blasi (1994) identified as a disconnect between homelessness which is a visible and extreme condition of poverty, and the larger context of poverty. Hopper (2003) has suggested that reconstructing homelessness as the endpoint on the continuum of poverty allows the full context of homelessness to emerge, including the individual factors that exacerbate or emerge from the condition of being “unhoused,” the structural factors that impact homelessness and the links to those who are vulnerable or under-housed.

Without adequate “in-kind” income support in the form of rent subsidy or direct support in the form of income assistance or earnings, formerly homeless persons will remain



at high risk of homelessness and poor health. Income and wealth, together indicators of economic security, are, like housing, socio-economic determinants of health. A large-scale study conducted in Britain investigated the ways in which poverty impacts health using population data for the 15 “worst health” and “best health” areas as defined by mortality rates (Shaw et al., 1999). A key finding of the study was that the magnitude of health inequalities increased as wealth and income decreased. The authors contend that observed health differences could be largely explained by differences in economic status. An early, but significant, Canadian study (Wilkins, Adams, & Brancker, 1998) conducted a similar analysis comparing the health status and socio-economic status (using census tracts) of residents of the poorest neighbourhoods and of more well-off neighbourhoods. The authors estimated that 22 percent of premature years of life lost could be attributed to income differences.

Accompanying the British investigation of health disparities was a policy analysis that clearly linked health inequalities to policy decisions made by the British government in the last 20 years. The final recommendation made in the report was that reductions in health inequalities could best be addressed by reducing income and wealth inequalities. Similar arguments have been made by Canadian researchers (Raphael, 1999, 2003; Reutter, 1995) who have clearly identified the association between poverty and poorer health outcomes.

For many formerly homeless persons, poor health has left them unable to work and reliant on various sources of income assistance. The National Council of Welfare [NCW] (2006) reported that in Ontario, a single employable welfare recipient receives only 34 percent of the income needed to reach the poverty line. A single individual with a disability receives considerably better income support, but it is still only 58 percent of the poverty line. Recent reports by the Ontario provincial government indicated grave concern for the high percentage of persons who would be eligible for disability support yet who are receiving the much lower monthly rate available from general welfare (MCSS, 2004; Ombudsman Ontario, 2006). The Daily Bread Food Bank [DBFB] (2005) found that of those food bank clients who reported a disability that restricts them from securing or maintaining regular employment, more 40 percent indicated income support from Ontario Works rather than from disability benefits.



Furthermore, nearly 37 percent of clients who reported a disability feel at risk of homelessness, a fear that is informed by the fact that 38 percent have actually experienced homelessness.

The fact that so many people fail to access disability benefits has been widely criticized. Advocates, academics and Ontario's Ombudsman have characterized the application, adjudication and review process for disability benefits as punitive and discriminatory (Beatty, 1998; DBFB, 2006; ISAC, 2004; Ombudsman Ontario, 2006). For those formerly homeless persons who are able to successfully secure disability benefits, the shelter component still falls considerably short of private market rent in most urban centres.

For formerly homeless persons who wish to transition to paid work, the barriers to employment are substantial, including risking disability status if in receipt of disability income support, high tax back rates on earned income, loss of health benefits, and difficulties in re-establishing benefits should the employment be terminated (MCSS, 2004; MISWAA, 2006).

Many older formerly homeless persons rely on Old Age Security (OAS) and Guaranteed Income Supplement (GIS) due to life circumstances that have limited their ability to participate in contributory retirement plans. Under-subscription and lapsed renewal of GIS remain an issue, as does limited coverage for prescription medicines and other health supports (Gazso, 2005; NACA, 2005). According to census data more than 600,000 Canadians over the age of 65 were living with a low income (Statistics Canada, 2003) and of those, 258,000 were living with incomes under the after-tax Low Income Cut-off (LICO), leaving an estimated 7 percent of seniors (NACA, 2005) economically insecure and potentially at risk of homelessness. Although the maximum support available to adults over age 65 is considerably higher than that available on general welfare and is marginally better than disability income support, non-eligible health expenses result in the net loss of income for many older adults, especially those with disabilities. Of particular concern is the persistence of poverty among older single women, who make up the majority of seniors living in poverty. A recent Statistics Canada release (2006) reported that more than 8 percent of widows were living in low income



after five years of widowhood, compared with 5.1 percent of widowers. Older women face social-structural barriers that limit their access to other means of achieving economic security such as occupational pensions and retirement savings plans (McDonald, 2006; Gazso, 2005; NACA, 2005).

A representative payeeship may help reduce economic insecurity and vulnerability to homelessness for some individuals who experience difficulties managing money. A representative payeeship, often referred to in Canada as a Public Guardian and Trustee, is an agent appointed to manage income and/or income support benefits for individuals judged at risk of poor money management or victimization. As a means of reducing the risk of homelessness, payeeship or trustee programs have been investigated in the literature examining risk factors for persons with serious/severe mental illness (SMI). SMI is typically defined as having one or more psychiatric disorders that seriously interfere with one or more aspects of daily life (National Institute for Disability and Rehabilitation Research, 2005).

Conrad and colleagues (2006), in a randomized trial of representative payeeship for persons with SMI, found statistically significant positive effects for the experimental group receiving payeeship services including improved outcomes on measures of substance use, quality of life, money management skill, and reductions in homelessness that approached significance. Also, less formal approaches to money management with formerly homeless persons, such as participation in a money management program (which is mandatory for ‘housing first’ interventions) have evidenced positive effects for housing stability (Tsemberis and et al., 2004).

Although an overall trend of reduction in the number of older adults living in poverty has been reported since the mid-1990s, the maturation of Canada’s retirement income system pension (Myles, 2000) and the changing aging demographic have propelled what Gazso (2005) refers to as a “crisis” policy discourse. More research addressing the potential impacts of this “crisis,” on marginalized groups, such as formerly homeless older adults who largely



rely on income support benefits, is critical to informing policy that ensures adequate economic security.

Discrimination and Stigma

Although most of the literature documents experiences of stigma and discrimination while homeless, there is some evidence that the experience of homelessness carries residual stigma once a person is housed (Gurstein & Small, 2005; Felton, 2003; Ridgeway et al., 1994; Rosenthal, 2000). Formerly homeless persons report that negative stereotyping persists, such as individual blame for having once lost housing and attributions of contamination and deterioration through contact with homeless services, like shelters (Boydell et al., 2000). This stigma is often institutionalized in housing settings where eligibility is contingent on having been homeless and therefore the identity of “homeless” lingers.

Not only does the residual experience of homelessness and its attendant negative stereotyping continue, but for many, a new layer of stigma is imposed: being “hard to house.” The term “hard to house” has evolved from the experience of service providers who were confronted with persons who present with such challenging issues that they are virtually ineligible for most housing. Gurstein & Small (2005) argue that such a label is dehumanizing and assigns deficits to the person rather than to a housing system that is unable to accommodate the most vulnerable and marginalized persons.

Perhaps the most tangible expression of the stigma attached to being “hard to house” is in the literature documenting NIMBYISM (‘Not-in-my-backyard’-ism). Community resistance to the development of alternative housing has emerged as a formidable barrier to establishing new sites (Connelly, 2003; Felton, 2003; Forte, 2002) and gives collective expression to the stereotypes of “threatening,” “unpredictable,” and “addicted” that haunt formerly homeless persons.

Classism

The stigma associated with the experience of homelessness is often subsumed under



the broader umbrella of people living in poverty. For formerly homeless older adults this is often layered with the double jeopardy of receiving income assistance and of residing in social housing. Stapleton (2003) conducted a number of focus groups investigating public opinion about persons receiving income assistance. The majority of focus group participants attributed poverty to an individual deficit from which the individual must recover, and assigned social citizenship on the basis of obtaining and retaining work.

The receipt of income assistance presents one layer of class-based discrimination. For formerly homeless persons, subsidized housing offers another source of exclusion and stigma. Arthurson (2004) suggests that public housing is a “repository” for the most excluded tenants and therefore all the disadvantage associated with such a marginalized status become embedded in the housing itself. Residents of alternative housing are frequently labelled the ‘deserving poor’ who, through character and behavioural deficits, have ‘earned’ the need for housing support (Rosenthal, 2000).

Pawson & Kintrea (2002) document the challenges in the UK in addressing stigma and social exclusion associated with social or alternative housing, noting that such housing has the capacity for generating social and spatial divisions between those in need of support and the mainstream. This process of exclusion occurs when housing processes constrain certain groups’ self-determination or enjoyment of civil rights (Sommerville, 1998). Research suggests that the formerly homeless exchange the stigma of “no fixed address” for that of tenure at an address which conveys disadvantage in seeking other housing, employment and social services.

Ageism

Literature that addresses age discrimination in housing has begun to emerge. Although most of the literature documenting ageism is clustered around discrimination in employment, researchers have found evidence of discrimination, especially for older adults, both in non-profit and private rental markets (Novac, Darden, Hulchanski, & Seguin, 2002; Spencer, 2005). A common example of discrimination against older adults is the limits imposed on



visitors' stays, which disadvantage older adults who may require support from family and/or friends beyond the guidelines for house guests (Spencer, 2005). More research is needed to investigate how housing discrimination impacts older adults' housing security and quality of life.

As mentioned above, there is a significant amount of literature on age discrimination in the labour force, but none of it pertains to formerly homeless adults and the challenging situation they face. For those who wish to work, finding employment is exceedingly tough for an adult whose age and experience of homelessness minimizes their options and skills required by the labour market. There is a significant gap here in the literature, yet on the other hand Hopper (2003) cautions against making work the "solution" to homelessness. While it may challenge stereotypes of laziness, many homeless older adults simply cannot work because of health problems.

Physical Health

Homelessness has an enormous impact on a person's physical health and well-being at any age. It is well documented that older homeless adults are in worse health than older people in the general population (10, 43, 44, 45 Frankish, Hwang & Quantz, 2005.) Several large-scale American studies, mentioned in the previous section, have indicated higher mortality rates among older homeless people, and that they are more likely to die from preventable causes than people of a similar age in the general population (44, 45). Also, the research suggests that health status for homeless persons is diminished, and many can suffer from co-existing health and functional impairments. For example, Hamel (2001) found in Massachusetts that 50 percent of older homeless adults had two or more "physical, psychological or addictive impairments."

The impact of housing and the resultant effects on the health status of formerly homeless adults is a new area of study. Hwang's (2005) systematic review of health interventions for the homeless found few controlled studies that showed consistent effects of housing on the physical health, mental health, or substance use of homeless adults. Hwang's



review favours medical research methodology: random assignment of participants to control and experimental groups. Controlled studies are understandably rare in homeless research because the control group must remain homeless for the purposes of the research. Obviously, this is a challenging problem and raises ethical concerns. The point remains that there are few studies, controlled or not, that address the health effects of housing homeless adults.

The other confound to isolating significant health effects for housing interventions is that formerly homeless older adults frequently enter housing with seriously compromised health arising from both “homeless effects” and accelerated “aging effects” from the conditions and stressors associated with being homeless. Further underlying conditions are often only diagnosed and treated once the person is housed. Therefore, self-report, scales and secondary health data may show poorer health status post-housing. Nevertheless, research strategies such as wait list controls should be pursued to clarify housing effects on the health and well-being of formerly homeless older adults.

A Toronto study of 295 rooming house residents—one-third of whom had been homeless—compared residents’ health status with that of the general population. The study found that the men had poorer health compared to the general Canadian population, while the women’s health was roughly the same as the general population. When the group of “roomers” were compared to other low-income people, they also tended to have poorer health (Hwang, Martin, Tolomiczenko, & Hulchanski, 2003). The authors concluded with the suggestion that future research should track health status from housing entry over time to isolate changes that might be attributable to characteristics of the housing.

Another Toronto study, evaluating an intervention with residents of “Tent City” found that once housed, the health of the formerly homeless adults initially improved, but then deteriorated for one-quarter of the residents (Gallant, Brown, & Tremblay, 2004). The authors contended that this deterioration was due to latent medical conditions that had previously gone unidentified or ignored.



While the physical health status of formerly homeless older adults remains an under-researched area, American research investigating health and/or well-being and levels of housing satisfaction of the elderly in the private market (Spencer 2002), or assisted living or community based care (Curtis, Sales, Sullivan, Gray & Hendrick, 2005; Cummings, 2002; Sikorska, 1999; Timko & Moos, 1990) indicates that self-reported health status and housing status are linked. While the populations studied are not formerly homeless, the main finding is that better perceived health status is strongly associated with satisfaction with housing and onsite care.

The links between housing and health remain difficult to isolate. For example, physical health and more general well-being are difficult to disentangle, and frequently variables outside typical dimensions of housing and health care, like “social support,” are found to be better predictors of health outcomes. In Cummings’ (2002) small-scale American study of psychological well-being of older adults in assisted living facilities, social support emerged as a key variable. When strong social support was present, the effect of functional impairment and poor health was no longer significant. The residents’ psychological well-being was not directly associated with the number of programs attended or number of contacts, but rather to the perception of the level of social support they received. The limitations of this study are important to note, since the non-random sample was made up of a small number of affluent white women and cannot be generalized to other older populations, particularly those who have experienced homelessness.

Similarly, Curtis and colleagues (2005) failed to find a significant effect for housing type. They found that the type of facility (adult foster homes, adult residential care, assisted living) did not predict satisfaction. This supports the notion that preference is completely personal and cannot be predicted or ascribed by others. Similarly, in a study where case managers and consumers were given the opportunity to assign the most appropriate facility to consumers, there was little agreement between the two groups (Baker & Prince, 1990). If anything, the few studies linking satisfaction with community-based care caution against designing a single, universal model of assisted living for the elderly. Instead, the varied



research findings suggest that a wide array of program and living options are critical to enhancing quality of life.

The relationship between physical health and housing for formerly homeless older adults is an area in need of further study. While current studies focus on the health status of homeless adults, savings in health care as a result of housing the homeless, or the health effects of housing satisfaction for the elderly, there remains a significant gap in the literature. The gap is perhaps best addressed, for now, by the research reviewed in the following sections addressing housing programs for the formerly homeless adults with mental health and/or substance abuse problems.

Mental Health

The literature on mental health and housing is a rich source of evidence on housing and health outcomes for formerly homeless persons. Most of the research samples, however, are from the general adult population of homeless persons and rarely isolate aging as a variable of interest. Given the high incidence of mental health issues experienced by homeless and formerly homeless persons (Raynault et al., 1997; Tolomiczenko et al., 2001), the literature remains highly relevant even if it fails to capture the added dimension of aging.

The Golden Report (Golden et al., 1998), a formative Toronto study on the issue of homelessness, concluded that approximately one-third of the homeless population suffers from serious mental illness (SMI). Serious mental illness is typically defined as having one or more psychiatric disorders that seriously interfere with one or more aspects of daily life (National Institute for Disability and Rehabilitation Research, 2005).

The relationship between homelessness and mental illness is conceived of in two ways: (1) an indirect association that suggests that individuals with serious mental illness (SMI) may “drift” into poverty due to difficulties sustaining employment and housing, and (2) a direct association maintaining that the social experiences of individuals who are poor increase the potential for the development of a SMI (Health Canada [HC], 2003).



Most authors acknowledge that both situations could occur as a result of living without adequate housing, but maintain that there is a stronger case for targeting interventions to the latter direct association (Rog, 2004; Wong & Solomon, 2002). Pathways to Homelessness, a study examining mental health prevalence and its impact on homelessness, found that only 3 percent of individuals surveyed identified mental illness as a precipitating factor to the loss of housing (Canadian Mental Health Association [CMHA], Centre for Addictions and Mental health [CAMH] & Ontario Mental health Federation [OMHF], 1997). This study also found a lifetime prevalence of 10.6 percent for SMIs among persons without housing (CMHA, CAMH & OMHF, 1997), indicating that many persons may develop SMI after losing their housing. Compounding the high incidence of mental health problems for formerly homeless older adults is that dementia is often confused with, and exacerbates, mental illness.

Although the over-representation of persons with mental illness in the homeless population has been recognized for some time, the direction of the relationship and significance to housing and mental health outcomes remains controversial. If mental illness is seen as an antecedent and risk factor for homelessness, it will tend to drive policy and programming that targets psychiatric treatment and assumes a linear progression through treatment contingent housing. Conversely, many studies have found that homeless and formerly homeless persons with poor mental health identify social and economic factors as critical to housing loss (Motjabai, 2005; Tolomiczenko, 1998) and therefore policy and programming that addresses economic and housing insecurity is emphasized. As Gaetz (2004) notes, the question of whether mental illness is a vulnerability factor for homelessness, or whether homelessness is a vulnerability factor for mental illness, will drive quite different policy responses.

Ultimately, the model of association between mental health and homelessness will impact mental health and housing interventions and their associated outcomes. A formerly homeless person who has a history of poor mental health prior to losing their housing may be less likely to experience significantly improved mental health when housed than someone who



developed poor mental health while homeless. Despite the challenges of mapping the association between mental health and housing, the literature shows substantial evidence of positive associations between housing and mental health outcomes for formerly homeless adults (Clark & Rich, 2003; Mares, Kaspro, & Rosenheck, 2004; Mares & Rosenheck, 2004). A recent outcome evaluation of a Toronto supported housing site found significant improvement in depressive symptoms, as evidenced by the contrast between scores on the Centre for Epidemiological Studies Depression scale administered on entry into the housing to scores on the same scale at two year follow-up (Jovcevska, Kittmer & Hinton, 2006).

Although the diversity of existing housing models and the lack of clear operational definitions limit systematic evaluation, Fakoury and colleagues' (2002) review of the literature concluded that clinically significant findings, taken collectively, provide support that immediate, non-contingent provision of housing to those who are homeless and experiencing SMI result in improved, sustained mental health and housing outcomes. Further research is required that better articulates the various models of alternative housing and that performs extensive multivariate analysis to determine which consumer characteristics predict more favourable outcomes in each housing model.

A review by Newman (2001) documented the qualities of housing settings that produce positive outcomes for people with SMI. These factors were good housing quality, wide dispersal in the community, social supports, smaller scale settings and a high degree of resident control and choice. These same qualities have been identified as key factors associated with resident satisfaction and housing stability for formerly homeless persons (Gulcur, 2003; O'Malley & Croucher, 2005; Yanos et al., 2004) and for the general population of older adults in community residential care settings (Curtis et al., 2005).

One of the most provocative findings linking positive mental health outcomes to housing is a neuropsychological study that found evidence of improved cognitive functioning once homeless persons with SMI were housed (Seidman et al., 2003). Seidman and colleagues (2003) looked at two housing interventions: group homes and independent housing. Although



overall improved neurological functioning was found in both housing conditions, those persons assigned to independent housing evidenced a decline in executive functioning. The authors suggested that this decline may represent the greater challenges, including loss of social structure and interaction, encountered during the transition to independent housing. Other studies, however, have indicated that formerly homeless adults experience significant challenges in transitioning to staffed housing settings (Ridgeway, et al., 1994; Yanos et al., 2004). These authors found that participants transitioning to staffed housing reported feeling patronized, less in control of their lives and more threatened by the behaviours of other residents.

Clark and Rich (2003) found significant differences in housing outcomes for formerly homeless individuals with substance use problems and low, medium and high severity of SMI. The study concluded that positive housing and mental health outcomes may be maximized by matching interventions to consumer characteristics. Similarly, a British literature review (O'Malley & Crouch, 2005) concluded that although there was recognition in the research of the frequent poor fit between accommodation models and needs, there was little clarity on how a better match could be achieved. The authors concluded that further research on “goodness of fit” between different housing models and consumer needs and preferences is necessary but difficult to achieve.

For example, Yanos and colleagues (2004) attempted to isolate associations between individual and program level factors but failed to find any significant effects. The authors attributed the absence of associations to the fact that formerly homeless persons have as highly subjective and intuitive conceptions of home as those held by the general population. Therefore, attempts to associate specific housing/support interventions with specific clusters of individual characteristics and preferences may be unproductive. Instead, several authors (Morgan, 2002; Nelson, Walsh-Bowers, & Brant Hall, 1998; Yanos, 2004) have suggested that research should focus on assessment tools and service/support models, which encourage and support client determination in the context of a broad menu of housing/support options.



Substance Use

Many studies have identified alcoholism and other substance abuses as a pervasive health problem for homeless and formerly homeless persons. American estimates of prevalence of alcohol dependence and abuse among homeless persons range from 59 percent to 68 percent (Velasquez, 2000), which is 5 to 7 times greater than what would be expected in the general population. Canadian estimates of alcohol abuse among homeless persons are similar to those reported in the USA (Hwang, 2004; Podymow, Turnbull, Coyle, & Wells, 2006). Contrasted with general population rates of harmful or hazardous levels of alcohol consumption in the range of 5 to 15 percent (Adalf, 2003; Statistics Canada, 2005), the higher incidence of alcohol and substance use among homeless persons poses serious health risks, limits social capital and is a formidable barrier to accessing and maintaining appropriate housing.

Hwang (2006) estimated that between 10 to 20 percent of shelter residents are chronically homeless and exhibit high rates of alcohol and substance use. The author concluded that for this group, interventions and housing that demand abstinence are unsuccessful. Other authors have come to similar conclusions, finding that for formerly homeless persons, alcohol and substance use problems are associated with limited access to housing, housing instability and poorer quality of life outcomes (Hurlburt, Wood, & Hough, 1996; Mares, Kaspro, & Rosenheck, 2004). Other authors have found that substance use issues are negatively associated with housing and health outcomes (e.g. Dickey, Latimer, Powers, Gonzalez, & Goldfinger, 1997; Goldfinger et al., (1999), Lipton et al, (2000) and Tsemberis & Eisenberg (2000).

Compounding the challenges that emerge from such high rates of alcoholism and substance abuse is that for many formerly homeless persons, substance misuse is frequently co-morbid with a psychiatric diagnosis (the pairing is often referred to as a “concurrent disorder”). Reardon and colleagues (2003) found that the incidence of concurrent disorders in a formerly homeless group was five times that reported by “never homeless” participants.



Harm reduction strategies that seek to reduce the adverse consequences of consumption without requiring abstinence are emerging as a model of housing and support that may allow individuals who are “treatment resistant” to secure housing and begin the process of making contact with health care providers (Hunt, 2004). Harm reduction programs have proven effective in stabilizing homeless persons and in improving their health and well being (Tsemberis et al., 2003). Podymow and colleagues (2006) evaluated a “managed alcohol” intervention that included close supervision, assistance with activities of daily living, on-site health care, and limited consumption (one standard drink hourly on demand during waking hours). In pre/post intervention comparisons, emergency department visits were significantly less, as were incidents involving the police. Program records and self-reports indicated a decrease in alcohol consumption. Similar positive outcomes were reported in an evaluation of an Ottawa harm reduction program employing an alcohol management program, which included greater housing stability, fewer hospital interventions and less interaction with the criminal justice system (Alderson-Gill & Associates, 2002)

Early outcomes from the Portland Hotel Society in Vancouver (Gurstein & Small, 2005) and well documented outcomes from the Pathways to Housing project in New York (Tsembersis et al., 2000; 2003) have shown that harm reduction is associated with significant improvements in health and housing tenure for formerly homeless persons who are actively using substances. For example, Tsembersis and colleagues (2000; 2003) reported high rates of housing stability for active substance users. In this study, more than three quarters of the participants assigned to independent housing with self determined supports (“housing first” model) were still housed at the 24-month follow up. Further, the participants showed no significant difference in substance use when compared to the control participants whose housing was conditional on treatment participation and abstinence.

The following elements identified by Vance and colleagues (2002) were outlined in the Environmental Scan prepared for the Toronto Drug Strategy Initiative (City of Toronto, 2005) as guiding principles for developing harm reduction housing: tenants may actively use alcohol and/or substance; abstinence is not a condition of tenancy nor grounds for eviction; safe,



respectful and appropriate behaviour is the focus, rather than the use of substances; and supplies and services that support safer use must be onsite or nearby. Further research documenting housing and health outcomes in the few existing Canadian harm reduction sites is essential to identifying best practices and replication.

Gender

Homeless men outnumber homeless women by a ratio of two to one. The gender division in the homeless population differs from the general population, where the number of women outnumber men (Cohen, 1999). Studies from the United States and the United Kingdom have shown that men have been homeless about 50 percent longer than women (Crane & Warnes, 2000; Rossi, 1989), while older women often become homeless for the first time later than men, in their mid-fifties (Cohen & Crane, 1996). Now that researchers are beginning to identify the different patterns of homelessness for older women, they have identified the need for appropriate and safe shelters, housing and services (McDonald, Dergal & Cleghorn, 2004).

A study of women and housing in Canada (Callaghan, Farha, & Porter, 2002) stressed that homelessness may be more prevalent for women than homeless “counts” reveal because homeless women are often the hidden homeless. Many homeless women are not living on the street because they are vulnerable to violence, and instead stay in cars, “double up” with relatives or friends, or live in unsafe, overcrowded accommodations. The same report contends that women are more likely to be at risk for homelessness because of greater income instability due to non-permanent employment, loss of income from separation and divorce, caregiving requirements, and the experience of domestic abuse, all of which can result in the loss of housing.

Callaghan and colleagues (2002) also emphasized the double jeopardy experienced by immigrant, visible minority and aboriginal women who can be at greater risk for homelessness because of racialized economic inequalities. In Victoria, British Columbia, the Women’s Housing Action Team conducted a small scale study which found that the economic and



political conditions of aboriginal women's lives fall below the standards for the rest of the population in Canada, placing them at risk for homelessness (Bilsbarrow, Craig, & Reitsma-Street, 2005). They found immense disparities in education, health and income, according to statistics on social indicators, that were attributed to colonization and cultural genocide. The women experienced ageism around employment and housing discrimination from landlords, contributing to severe employment and housing instability. Women between the ages of 40 and 65 were even more vulnerable, since they continued to have responsibilities for family and community but had limited access to employment, pensions or subsidized housing (Bilsbarrow, et al., 2005). Women with visible and invisible disabilities experience the further challenge of finding housing that accommodates their different abilities (Alcorn, Gropp, Neubauer & Reitsma-Street, 2005; de Champlain, 2005). These studies collectively emphasize the need for housing and supports that are sensitive to the unique needs and preferences of women, especially women from diverse communities, aboriginal women and women with different abilities. More research is needed to articulate housing models that best accommodate gender, diversity and ability.

Cohen and colleagues (1997) developed a predictive model of residential status and applied the analysis on a sample of 201 homeless older women two years post-housing. Of the sample, 53 percent were "nondomiciled" at follow up and 47 percent remained "domiciled." Only two variables were significant independent predictors of subsequent housing status: perceived support and the number of community facilities used. These findings underscore the importance of systemic factors in creating and maintaining homelessness among aging women.

Ethno-cultural Diversity

Research in the areas of housing and homelessness is now more frequently examined in terms of age, gender, ethnicity and "race." Researchers continue to encounter difficulties in accessing diverse communities and therefore these groups remain under represented in the literature. A few studies, however, have been able to document housing instability and homelessness in these communities. For example, a study on the increase of homelessness in



Latin American and Muslim communities in Toronto identified that homeless immigrants and refugees were not accessing needed services because of cultural barriers, the stigma of homelessness, and a lack of outreach by agencies (Zine, 2002). The study emphasized the role of weak social ties (acquaintances beyond one's own social group) in accessing housing help. For these groups, weak ties can diversify the individual's resources and lead to socio-economic and cultural resources beyond one's own community.

Widespread discrimination in accessing housing has been reported in the literature examining homelessness and housing in immigrant and/or ethno cultural communities (Hulchanski et al, 2003). Although limited by the difficulty in accessing homeless and at-risk persons from diverse communities, studies have consistently found that the health and social service sectors must develop models sensitive to cultural norms and behaviours of homeless persons from diverse communities (Donahue et al, 2004). Hulchanski (1997) identified a series of barriers experienced by recent immigrants to Toronto that included primary barriers such as "race," ethnicity and gender and secondary barriers such as level and source of income, knowledge of the housing system, language/accent, household type and size, knowledge of and experience with institutions and culture. Further research identifying models that address these barriers and facilitate access to appropriate housing and supports for diverse communities is required.

Zine (2002) also found that the supportive housing sector needs to better address the issue of diversity. Research is continuing in this area with the Best Practices in Developing Culturally Competent Supportive Housing Models Project, a partnership between the Centre for Addiction and Mental Health, the City of Toronto, and the Supportive Housing and Diversity Group. The project intends to identify barriers to access and then develop culturally sensitive tools for housing providers, train staff, engage in capacity building and coordinate services to meet the housing needs of ethno-racial and ethno-cultural clients with mental health and addictions issues.



Social Capital and Social Networks

Social capital is defined as the resources available to individuals and groups through their social connection and interactions with others. The definition is evolving and remains contested but most authors situate it as a public good that is provided and shared by members of the community. The collective dimension of social capital is what most clearly sets it apart from such individual-level constructs like social networks and social support. Although these individual factors contribute to the collective social capital of a community, the terms, though related, are distinct. Cannuscio and colleagues (2003) illustrate the distinction with the example of an individual who may lack social ties on a personal level but resides in a community with rich social ties. Communities that are rich in social capital convey benefits to community members through collective resources, such as organized advocacy groups that may campaign for community health centres.

Social capital is particularly relevant to individuals who may experience disadvantage because of factors such as age or membership in a marginalized group. Formerly homeless older adults frequently lack social networks both because of the erosion of social connections as they age and because of the isolation and alienation that accompanies the experience of homelessness. Mares and Rosenheck (2004) compared housed and homeless persons on several mental health dimensions including social capital and found that homeless persons tended to reside in communities with lower levels of social capital than formerly homeless persons. The absolute level of social capital, however, was quite low even for the formerly homeless group, suggesting that this group tends to find housing in communities with lower levels of social capital.

Won and Solomon (2002) reviewed the mental health literature on community integration and found that most research investigating housing and support factors as predictors of community integration tended to focus on participation in community activities and use of community resources. The authors suggested that research should adopt a more fine-grained analysis of individual factors such as social engagement with community members and perception of community membership, as well as community level factors such



as safety, acceptance of diversity, proximity to resources and public space and forums for interaction.

Cannuscio and colleagues (2003) proposed that for individuals who have limited social networks, housing interventions may have the capacity to endow or stimulate social capital. The authors used the example of assisted living developments for elderly persons to illustrate how both built environments and programming can stimulate social capital. Citing case studies from northern Europe, they isolated key components fostering healthy community building, including situating housing in vital community hubs and creating forums where members of the broader community and residents can easily congregate.

Ridgeway and colleagues (1994), however, cautioned that alternative housing settings can just as readily foster isolation and disconnection and that housing models must be sensitive to the needs of individual tenants and allow for a high degree of self-determination. The authors noted that many studies have shown that homeless persons must be engaged and served on their own terms. Formerly homeless persons must exert similar control over their housing and supports. Control over the selection of housing and over accompanying supports was found to be a critical determinant of a resident's sense of home. Further, they found that in establishing a sense of home, a sense of membership in the community was also achieved. Yanos and colleagues (2004) found that community integration and residing in communities with high levels of social capital were critical to the well-being of formerly homeless persons in the early phase of housing. The authors highlighted the significance of neighbourhood level characteristics in shaping formerly homeless persons sense of comfort and connection within the community.

Further research investigating the social capital and community integration of formerly homeless persons is needed to identify housing and support interventions, which might mediate the lack of social capital present in many of the communities where alternative housing is located.



Refining a Solution: Models of Best Practice

The first step to housing the homeless is securing the housing. Efforts to house older homeless adults reveal different barriers, models and successes. For example, Hamel (2001) recounted the effect of “shelterization,” whereby the experience of living in a shelter fosters dependent behaviours in the residents, the loss of life skills, and prohibits the development of new routines or changes in lifestyle required for becoming housed. Hamel found that outreach by housing workers to homeless adults in the shelters was necessary to combat “shelterization.” The outreach workers maintained a relationship with the adult until they were stabilized in their housing. Continuity of support from shelter to housing and consistent case management are frequently identified as a best practice in accessing and maintaining housing.

The Closer to Home study analyzed six housing programs across the USA for “difficult to serve” homeless adults (Barrow, Rodriguez & Cordova, 2004). Three of the programs targeted housing shelter/lodging residents. The other three programs focused on assisting formerly homeless adults in maintaining their housing. The latter programs sought to sustain housing for people with unstable housing histories. The housing tenants were younger adults with shorter homeless histories and more connections to treatment and support systems. The program used a team case management approach to keep residents housed. Establishing relationships with and support from the workers helped more than 77 percent of the tenants remain housed after two years, once again pointing to the success of a case management approach (Barrow et al., 2004).

Others, however, though recognizing the value of case management, have found that the intervention of primary significance is access to affordable housing. Shinn, Baumohl & Hopper (2001) reviewed studies of housing for mentally ill homeless adults with and without case management. The authors found that access to housing subsidies was the most significant predictor of housing outcomes.

Despite adopting best practices in relationship building, case management and housing subsidies, some studies have encountered serious setbacks in achieving positive outcomes for



chronically homeless adults. The shelter/lodging component of the Closer to Home project (Barrow et al., 2004) encountered the challenge of entrenched homelessness. These residents were older adults with mental and physical illnesses and more than four years of homelessness. The workers created solid relationships with shelter residents, but in spite of this, some residents were unable to secure housing and refused to accept the stigmatized identities that the housing process required. The success in re-housing these clients was low, and less than half of the “near permanent residents” of the shelter/lodging programs were able to transition to permanent housing at two year follow up. Consequently, the authors concluded that early intervention and prevention of entrenchment in the shelter system are best practices for achieving positive health and housing outcomes.

Warnes and Crane’s (2000) research on the resettlement of older homeless adults also noted that the longer the client had been homeless, the more resistant the individual was to services and the more difficult it was to resettle. The authors also concluded that a clear best practice is early intervention and access to housing.

‘Housing First’: A Paradigm Shift Toward Early Intervention

Tsemberis and colleagues (2003) maintain that a “housing first” approach is critical to engaging homeless mentally ill adults. A primary barrier to outreach and subsequent housing is that many programs have threshold expectations, such as abstinence and medication compliance. The authors report that the development of the Choices Unlimited program has significantly reduced these barriers. Another key element of the program is that it provides continuity in relationships from outreach to housing with a single case manager following an individual through engagement, placement, transitioning and housing maintenance. The drop-in “Choices Centre” has staff trained in “psychiatric rehabilitation technology” that emphasizes consumer choice. The “Choices Centre” was compared to traditional drop-in centre programs that emphasized a predetermined sequence of services designated by program planners and clinicians. The authors report that the consumer driven outreach and drop-in program proved significantly more effective in engaging homeless persons than the linear continuum of care programs, but it did not reduce homelessness because consumers could not



meet conditions of access (“housing readiness”: treatment compliance and sobriety). The Pathways to Housing project was developed to address the systemic barriers imposed by the housing system.

The Pathways to Housing project offers the “hard to house” an independent furnished apartment at the outset. Outreach, engagement and housing occur concurrently with support from Assertive Community Treatment (ACT) that provides multiple services including: money management, laundry, crisis intervention and vocational rehab. Numerous studies of the project have shown that choice among housing options were correlated with housing satisfaction, stability and well-being for mentally ill homeless persons (Padgett, Gulcur, & Tsemberis, 2006; Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Fitzpatrick, 2004). Housing outcomes for the Pathways’ Housing First program were in the unprecedented range of 80 percent or better retention between housing entry and two-year follow-up (Tsemberis et al., 2003; 2004), have been widely replicated and despite a dedicated harm reduction approach and on-demand mental health support have never evidenced compromises to mental health or substance use symptomology. The impressive results of the Pathways Housing First program prompted the American Psychiatric Association to award the project its Gold Achievement Award in the area of community-based programs (Psychiatric Services, 2005).

Other Best Practices for Housing the Homeless

Hamel (2001) considered three successful supportive housing models for formerly homeless people in Boston and identified interdependence and collaboration of providers across specialties of health, housing and social services as key factors in serving complex populations. Hamel’s (2001) model of an interdisciplinary team of rehabilitation professionals, nurses, social workers, community service administrators, outreach workers, nutritionists, and occupational and physical therapists is a best practice tool (care map) that can be utilized with the homeless older adult population. This model draws on multiple and flexible sources of support similar to the “delinked services” associated with “housing first” models.



A study of supportive housing provision for 253 homeless older adults in California (Proscio, 2005), nearly all of whom were dually diagnosed with mental illness and chronic substance use, reported significant reductions in health care utilization and found that nearly all of the residents were able to stabilize in housing for at least one year. Preliminary results indicate that of the 253 homeless adults, 81 percent remained in housing after one year and 62 percent remained after two years. The two sites used a model of integrated and coordinated resident services from several specialized provider agencies working as a team.

This innovative model emphasizes the role of Integrated Service Teams of 30 housing/service agencies created for 15 housing sites. Each team provides a combination of care: medical, case management, mental health, substance abuse, housing retention, and life and vocational skills. The author contends that such an integrated model replaces costly fragmentary service with sustained, preventive and permanent solutions to chronic homelessness. Tenants live in an independent, unrestricted environment that does not demand abstinence or any other requirements prior to housing. Comprehensive care coupled with a “low demand” housing setting has produced better results for the most difficult-to-reach homeless persons at lower cost than the acute and institutional care typically accessed by chronically homeless persons. Like the Pathways project’s “housing first” approach, the California supportive housing in this study relies on services that are de-linked (but not necessarily off-site) from the provision of housing and a “low demand” harm reduction framework that allows for client determination over mental health and substance use interventions. The model has been developed into the Housing, Health and Integrated Service Network (HHISN) and is being expanded and replicated in eight counties in the state of California (Bristol & Greiff, 2002).

Harm reduction housing, as advocated in the “housing first” and “integrated team” models, is an emergent best practice for a segment of homeless and formerly homeless adults whose substance use poses significant barriers to housing. Harm reduction approaches continue to be contentious in some areas such as housing but are more widely endorsed in other areas such as needle exchanges (Hunt, 2004). Harm reduction housing need not follow



all the tenets of a 'housing first' framework; for example, supports may be directly linked to the housing through onsite staffing or agency contracts.

While advocates argue that harm reduction housing is critical to engaging and housing those homeless persons who are actively using substances, few housing sites have adopted formal harm reduction policies. Housing that requires abstinence and/or participation in treatment programs as a condition of tenure excludes a significant number of homeless persons, especially, as Hwang (2005) has noted, those persons who are chronically homeless and who have very high rates of alcoholism. The few harm reduction housing studies published have found positive housing and health outcomes (Tsembersis et al., 2003; Gurnstein and Small, 2005). Examples of Canadian harm reduction housing currently being evaluated are the Portland Hotel Society in Vancouver and Seaton House Annex in Toronto.

A CMHC (2004) report on housing options for elderly and/or chronically ill shelter users also stresses the significance of addressing mental health and substance use in the context of alternative or assisted living. The report, however, acknowledges that the demand for 'best practice' housing is considerably greater than the supply. Best practices identified in the report include that the site should have between 20 and 50 units, communal rooms, a case room, links to many services, and that key staff supports should consist of life skills development professionals, nursing, social work, recreational aides, personal care, and housecleaners. Key policies should take account of: client-centred and harm reduction programming.

Another best practice identified in the literature is the significance of privacy and control when housing formerly homeless adults. Anucha and Hulchanski (2003) found that for "hard to house" tenants in shared housing, interpersonal conflict with their roommates increased the risk of eviction. The lack of privacy afforded in shared living arrangements is a major shortcoming, and the authors concluded that privacy is an important aspect of adequate housing for vulnerable populations. Preference for self-contained units is clearly evident in the



literature investigating the preferences of formerly homeless adults and of older adults from the general population.

Best Practices in “Aging in Place”

Alternative housing such as “service-enriched”, “assisted”, “supported” or “supportive” housing for older adults is emerging as a preferred option that allows older adults to remain in community-based housing rather than in institutional settings. Alternative housing as a model of “aging in place” has been favourably assessed on such dimensions as health, well-being, social support and social capital. Available research demonstrates that service-enriched housing promotes resident satisfaction, successfully provides service to frail populations, and supports aging in place (Pynoos, Liebig, Alley & Nishita, 2004). Originally targeted at the affluent elderly, its availability in USA is still limited and it is not often accessible to low-income older adults (Mollica, 2003; Pynoos et. al, 2004). As the section discussing the fiscal implications of alternative housing demonstrates, alternative housing not only adds tremendous value to the wellness of older adults but has significant value per dollar of government expenditure. Recent figures reported by the United Way (2005) indicate that regional average annual costs to the MOHLTC for supportive housing services in Toronto were \$6,984.27, while estimates of annual costs to the government for long-term care services were in the range of \$24,000 per year (OANHSS, 2005).

Pynoos and colleagues (2004) suggest that low intensity programs involving only service coordination can support aging in place and help maintain frail older persons. Higher intensity programs for more severely impaired persons, for instance, assistance with unscheduled activities (toileting), supervision (for dementia), or more medical assistance, may extend the option of community living for older adults with higher needs. The authors, however, found that even the “higher needs” older adults in the community were generally somewhat less physically and cognitively impaired than residents of nursing facilities indicating that institutional care will still be required for some older adults.



The capacity for alternative housing to provide a “best practice” model of aging in place was further highlighted in a recent United Way (2005) report investigating health and housing outcomes for older adults living in supportive and social housing. The findings from the report challenged conventional assumptions about thresholds for institutional care and the residual status assigned to community supports outside of the traditional health sector. Almost all the older adults in the study met the criteria for placement in a long term care facility yet with minimal supports like housekeeping, grocery shopping and for some, supports for personal care, which helped them continue to live independently in the community. Further, for those living in housing with onsite support, the use of costly emergency services was reduced, leading the authors to conclude that community supports for aging in place are not an “add on” to an already overburdened health care system but rather a cost effective alternative to acute and institutional care.

Although the evidence is mounting that alternative housing can accommodate a diversity of needs and forestall higher costs for institutional care, given the heavy investments made in long term care beds (Coyte, Laporte, Baranek, & Croson, 2002) the question may be whether the shift can be made by individuals and policy makers from facility-based to community-based housing and care. Sohng’s (1996) study of the relocation of 25 mentally ill elderly from nursing homes to supportive care in Washington State identified the challenges of moving from institutional care to community-based living arrangements. Clients were accustomed to high levels of care, and exhibited high levels of dependency, which required intensive nursing care and supports to daily living, including money management. The author reported that it was difficult to find a balance between support and independence to promote autonomy. Also, the author contended that the problem with the idea of “choice” was that it often was at odds with considerations of safety and health, and treatment plans. Despite these difficulties, consumers’ skills, sense of well-being and satisfaction with their apartment improved over time. After the initial year, staff reported that they had underestimated the potential of the consumers. A critical recommendation emerging from the study was the necessity of having enriched supports during the early stages of housing, otherwise a transition from higher to lower levels of support may place this vulnerable population at risk.



Best Practices in Inclusive And Accessible Housing and Supports

There are many reasons why people are excluded from appropriate housing and supports, such as gender, age, ethno-cultural identity, differential ability, income source, and status. For example, Zine's (2002) study found that for ethno-cultural communities, informal networks were more likely to lead to housing than mainstream services, even though finding housing for this group proved very difficult because of ethno-cultural discrimination and stigma.

For formerly homeless older adults these barriers are further exacerbated by the lingering effects of having experienced homelessness. Not only are individuals unable to access services but the services themselves are often inappropriate to the needs of diverse communities. A best practice that addresses these barriers is to ensure that supports are responsive and flexible through outreach, portable supports and through the development of culturally-sensitive housing. For example, the Program of All-Inclusive Care for the Elderly (PACE), was created by On Lok Senior Health Services in San Francisco. The elderly in the programs must live within a geographical area close to the PACE centre but they can receive services in their home or at the centre, depending on their health and preferences. Again, the model employs interdisciplinary teams to manage medical and nonmedical services such as transportation, attending recreational and educational programs, having meals at the centre or at home, supervision of medication, social work services and personal support services. The program operates in 19 states in the USA (Bristol & Greiff, 2002).

Comprehensive Home Option of Integrated Care for the Elderly (CHOICE), located in Calgary, is the Canadian version of the PACE program. CHOICE helps older adults to live in dignity and with autonomy, stressing sensitivity to changing needs. The service providers use the phrase "services follow the senior" to describe the flexible range of health care options and social supports available. Portable, flexible supports offer the advantage of reaching older adults in the home/community where they live and therefore may help engage older adults from diverse communities. Further, as Cox (2001) notes, flexible on-demand supports are cost



saving, attractive from a policy perspective, promote independent living and may eliminate or delay the need for expensive on-site nursing.

Another best practice to accessing and engaging older adults from diverse communities is onsite, culturally-sensitive housing supports. The United Way study (2005) concluded that supportive housing with intensive case management was able to overcome many of the barriers to accessing services both by coordinating off site supports and by providing linguistically and culturally appropriate onsite support.

Gaps and Future Directions

As stated in the introduction of this review, the primary gap in the available research is the absence of studies that make links between homelessness, alternative housing, and aging. This gap is addressed studying this present study, which investigates all three dimensions as they relate to housing, health, and housing outcomes for formerly homeless older adults. Further, issues that are evident across content clusters are shortfalls in measurement, the lack of research that encompasses issues of diversity and inclusion, and the scarcity of research that makes explicit connections between research, policy, practice and communities.

Methodology and Measurement

In a recent review of the literature investigating population aging and emergent housing and community needs, the Canada Mortgage and Housing Corporation (CMHC) concluded that available knowledge was inconsistent and out of date (CMHC, 2005). A key problem identified in the review was the overall lack of evaluation. The lack of evaluation must be addressed by a better articulation of the different models of housing and support and the development of measurements sensitive to the relative efficacy of each model.

A future direction for research identified by several authors (Proscio, 2000; O'Malley & Croucher, 2005; Yanos et al., 2004) is the development, piloting and evaluation of assessment tools aimed at achieving a better a fit between individuals and available



housing/support options. Another area where measurement tools are underdeveloped is in evaluating well-being. Attention to quality of life measurement beyond that available with mood and health scales was described by number of authors as missing in the research (Curtis et al., 2005; Baker & Prince, 1990). Although a growing body of conceptual work has been done defining social inclusion and other dimensions of wellness, few measurements have been developed to evaluate these constructs.

Inclusion and diversity

Another methodological concern is the scarcity of participatory research that integrates the lived experience and knowledge of homeless and formerly homeless older adults in the design of research and its implementation (Frankish et al., 2005). Inclusive methodology might also address a major gap in the Canadian knowledge base identified by Hodge (2005), namely the paucity of research about the experience of ethnic older adults. Hodge (2005) maintains that public policy decisions made about housing and other supports (and the research that informs them) must be sensitive to the needs of members of diverse communities. Most current policies and research regarding older adults and their communities are based on what we know from “non-visible” older adults. Future research must strive to reach out to these communities and participatory research models may afford better opportunities to achieve this goal.

Interaction of Research, Policy, Practice and Communities

A recent report by the CMHC (2005) stressed that governments have not provided a vision, goals or organizing frameworks for building knowledge and practice in a systematic manner to prepare for population aging and housing needs. The report suggests that the government and other consumers of research find that there is little in the literature about the way that the population is aging and the impact of immigration, diversity in aging populations and other changing socio-economic factors (CMHC 2005). Too little research has investigated the interaction between individual and structural factors and their impact on formerly homeless older adults. Although the issue of isolating the mechanisms by which health and



well-being are influenced by housing is challenging, several authors (Hwang et. al, 2005; Raphael, 2003) have highlighted the necessity for greater attention to articulating how housing acts as a structural determinant of health.

The nexus of the individual and structural factors and how these factors interact over time might be best investigated by using a life course analysis. A life course perspective not only captures the dimension of time, but it links the structural and the individual and makes transparent the implications of research to policy and practice (Bernard, & Li, 2006). Although longitudinal data is notoriously difficult to obtain from homeless populations, it is worth pursuing. Future research should adopt a life course analysis that could inform targeted preventive policy and programming, as well as help clarify and refine our understanding of housing as a social determinant of health.

Integration of community practice knowledge is another issue for future research. Iterative research that articulates, refines and evaluates practice models would allow research to better identify best practices at a program level and improve its usefulness to communities outside of academic circles. Specific areas identified in the research include: interdisciplinary and cross-cutting programs that better align health and social service provision (United Way, 2005; Pynoos et al., 2004; Coyte et al., 2002), harm reduction programs (Frankish et al., 2005), and mechanisms for knowledge transfer of best practices across communities and jurisdictions.

Finally, in the context of scarce resources further research evaluating the relative cost effectiveness of various housing/support interventions would help inform both policy and programming for formerly homeless older adults and enhance the value of these interventions to government, political, nonprofit and civil society communities.



SECTION 2: METHODOLOGY

Data Collection

This was a multi-method, two-site study (Toronto, Ontario and Calgary, Alberta) that collected data from five sources, as follows:

- (1) a comprehensive review of the literature;
- (2) a non-random survey of older adults in supportive housing (n= 237) with 201 participants in Toronto and 36 in Calgary;
- (3) in-depth qualitative interviews (n = 53) with 35 formerly homeless older adults in Toronto and 18 in Calgary;
- (4) six focus groups: four with service providers in Toronto (n = 17) and Calgary (n = 28), and two with formerly homeless, older adults who live in supportive housing in Toronto (n = 15) and Calgary (n = 9); and
- (5) secondary data analysis of provincial health care utilization data of 136 consenting participants in Ontario to track their utilization of formal health care services before and after becoming housed.

Comprehensive Review of the Literature

A comprehensive literature was conducted at the commencement of this study to inform the data collection tools that were developed and to serve as a foundation for the interpretation and understanding of our findings. The literature collected and presented was retrieved primarily from a number of databases such as: Ageline, Academic Search Premier, Family and Society Studies Worldwide, PsycINFO, Social Service Abstracts, SocINDEX, Sociological Abstracts, caredata, CINAHL, ProQuest, SourceOECD, MEDLINE, and PsychInfo.

Search queries using keywords were performed such as: aging, elderly, seniors, older adult, health, mental health, addictions, poverty, social determinants of health, homeless,



housing, supportive housing, supported housing, alternative housing, assisted living, social inclusion, and housing models.

Given the dearth of published literature in this area and the relevance of “local” reports, a search of the World Wide Web was also conducted to get at the “grey” literature; publications not published commercially or indexed by major database vendors.

Design of the Data Collection Instruments

The primary sources informing the development of the research methodology were a preliminary literature review and one focus group in each of the two cities with a blended group of service providers and formerly homeless older adults. Another key resource informing the construction of the data collection instruments was the findings and methodologies utilized in the project lead’s previous study that investigated the experiences of homeless older adults in the City of Toronto.

Drafts of the data collection instruments and relevant consent forms (Appendices B and C) were submitted to the University of Toronto Ethics Review Office and the University of Calgary’s Conjoint Health Research Ethics Board. Ethics approval was granted in the spring of 2005. Drafts of both the quantitative survey and the semi structured (qualitative) interview guide were circulated to a community based advisory committee and to all members of the research team. Subsequently, final drafts were piloted with four formerly homeless older adults, revisions made and hiring and training of interviewers commenced (Appendix C). All the research associates hired to conduct the interviews are either social work students or social service workers. Interviewing took place from the fall of 2005 until the spring of 2006.

Access to Health Care Utilization Data Files

Concurrent to the finalization of data collection instruments and training of interviewers was the ongoing negotiation to access personal health information from the Ministries of Health in Ontario and Alberta. Consultations were undertaken with Mohammad Agha of the Institute for Clinical Evaluative Science (ICES) and Tahany Gadalla, Assistant Professor, Faculty of Social Work University of Toronto to facilitate the negotiation process



and to help the team select the appropriate variables for the study. Access to data from the Ontario's Ministry of Health and Long Term Care was granted in June 2005. Access to the Alberta data was ultimately not required because many of the Calgary research participants would not permit access to their personal health information.

Sampling

Purposive sampling was used to ensure that the appropriate older persons were included in the sample. The eligibility requirements for participation in the study were as follows:

- Men and women 50 years of age and over (as indicated by a significant body of literature that supports the hypothesis that homeless older adults experience “accelerated aging”);
- Men and women who were previously homeless and were currently housed in supportive housing or supported housing with community supports for approximately two years
- Men and women who met the criteria above and who were willing to participate

With regard to the housing requirement, the main criteria was that the older adult was housed in supported housing (independent housing with de-linked [off-site] services).or supportive housing (housing with onsite support).

Fifty-three of the 237 participants of quantitative interview were invited to participate in the face-to-face qualitative interview.

Recruitment

In order to recruit formerly homeless older for the study, staff in programs and agencies who work with older people and housing and homelessness were used as the logical link between the researchers and the participants. Ongoing outreach to the community of service providers in both Toronto and Calgary (see list of participating agencies, Appendix D) ensured that an extensive and diverse base for recruitment was in place. Recruitment and information



materials were designed for use by participating agencies (Appendix A). Information sessions were held with approximately 20 agencies in Toronto to further promote the study. Agencies were contacted by the interviewers and research coordinator, and helped to refer clients who met the criteria and agreed to be interviewed. Participants also self-referred to the study as a result of postings at agencies. Throughout the course of the study, the research coordinator and interviewers made contact with approximately 60 agencies in Toronto and Calgary that serve the homeless or older adult populations.

Staff from each agency were asked to identify any older persons who met the sampling criteria. A list of the criteria was made available to the agencies to help them to recruit participants. When the agency staff identified a candidate for the interview, they asked the older adult if they would talk to the researchers about the study and then the researchers explained the study and asked for voluntary participation. If the participant met the criteria for the long or short interview and decided to enter the study, a private and safe place for the interview was found that was acceptable to the respondent (an office at the participating agency, a private room at the Institute for Life Course and Aging, etc). Signed consent was required of the participants. They were given a \$20 honorarium for the survey interview and a \$30 honorarium for the qualitative interview, to compensate them for their time, for which a receipt was issued.

Description of the Data Collection Instruments

The Quantitative Survey

Questions for the survey were obtained from three sources. First, questions were used that had been used in a previous study done in Toronto with the homeless population; for example, the questions related to alcohol, and tobacco were obtained from a survey already piloted and administered successfully to this group. Second, questions were used from the National Population Health Survey (NPHS). For example, the list of health and community services, the checklist of health problems, and questions related to vision, hearing, speech, mobility, and nutrition, were similar to those in the NPHS. Finally, standardized measures



were used to measure health status, orientation-memory-concentration, problem drinking, activities of daily living, mood, and social support. These scales were chosen because they were frequently used, were easy to administer to the population in terms of length and wording, and the questions were relevant to older homeless adults. The survey questions were organized under a number of categories 1) demographics, 2) experience of homelessness and aging, 3) recent housing history, 4) supportive housing, 5) use of health services, 6) use of community services, 7) alcohol and tobacco use, 8) health status, 9) checklist of health problems, 10) orientation-memory-concentration, 11) activities of daily living, 12) mood, 13) family, 14) social support, 15) social isolation, 16) life satisfaction and 17) income. (Appendix C) Although quite comprehensive, we structured the survey so that it should take no more than one hour to complete to prevent fatigue on the part of the participants given some of their health issues. The following is a brief description of each of the standardized measures employed in this study.

1) Health Status: SF-12

The SF-12 is a generic measure of health status. It consists of 12-items, and includes 1 or 2 items related to eight health concepts; physical functioning, role-physical, bodily pain, general health, energy/fatigue, social functioning, role-emotional, mental health, and change in health. There are two summary scales that are produced from the F-12; the Physical Component Summary (PCS), and the Mental Component Summary (MCS). The scoring for both scales use norm-based methods. Both the PCS-12 and the MCS-12 scales are transformed to have a mean of 50, and a standard deviation of 10 in the general U.S. population (Ware et al., 1995) All scores above and below 50 are above and below the average in the US population respectively. Each one point difference in scores is one-tenth of a standard deviation. Scoring involves four steps; reverse code four items (#1, #8, #9, #10) so that a higher score means better health, create indicator variables scored 1 or 0 for the item response choice categories (creating 35 indicator variables), weight individual variables using regression coefficients from the general US population, and aggregate them, and add a constant to these scores so they are standardized to have the same mean as the SF-36 in the general US population. This scale has been widely used to measure health status in other studies.



2) Orientation-Memory-Concentration: MMSE Short Blessed Test

The Orientation-Memory-Concentration Test, is a validated short version of the MMSE (73). It consists of 6-items each weighted with a different value. The first item is weighted with a 4, the next two items get a weight of either 3, and the last three items get a weight of 2, to produce a maximum summary score of 28. Each item contains a maximum error. The first three items have a maximum error of 1, the fourth and fifth items have a maximum error of 2, and the last item has a maximum error of 5. The scale is scored positively, subtracting from maximum (for item) for each error. This procedure produces a score between 0-28, with a higher score being better. Scores over 20 are considered within the normal range

3) Problem Drinking: the CAGE

The CAGE scale is a four item, self-report test used to screen for problem drinking. Affirmative answers to each of the four items are assigned a value of 1 and a cut-off score of two or higher is considered indicative of problem drinking. It is brief, easily administered, has a high level of clinical validity, and has been used in other studies. In a sample of patients in an alcoholic rehabilitation service, two or more affirmative responses on the CAGE identified all individuals with acknowledged alcohol dependence and 97% of the heavy drinkers but only 4% of non-alcoholics (Ewing, 1984).

4) Activities of Daily Living: KATZ IADL Index (IADL)

The Katz Index for measuring activities of daily living has been widely used among older people living in hospital, rehabilitation, or nursing home settings (Katz, 1970). This index consists of 7 items that are scored accordingly; no help, help, or unable to do. The number of answers responded to as either help, or unable to do, is summed. A greater score is indicative of greater physical impairment.

5) Mood: Geriatric Depression Scale (GDS Short Form)



The short form of the Geriatric Depression Scale (GDS-SF) is used to screen for depressive symptoms in older adults and to evaluate the clinical severity of depression. The GDS-SF is a 15 item self-report inventory that requires participants to respond yes or no to a series of questions regarding their mood in the previous week. Affirmative responses are assigned a value of 1 for 10 of the items and five items are assigned a value of 1 for 'no' responses (items 1, 5, 7, 11, and 13). The highest possible score is 15. For clinical purposes, a score greater than 5 suggests depression and warrants a follow-up interview. Probable depression is indicated by scores greater than 10 (Sheikh & Yesavage, 1986). It has been validated as a screening tool for depression among older adults in general practice (D'Ath, Katona, Mullan, Evans, Katona, 1994).

6) Social Support: UCLA Three-Item Loneliness Scale

The Three-Item Loneliness Scale is a shortened version of the 20 item UCLA Loneliness Scale with four response categories, which asks respondents to rate their level of loneliness according to four categories in response to statements such as "I lack companionship." The three-item scale was designed for telephone interviews, the statements were reworded into the second person (e.g., "How often do you feel that you lack companionship?" and it uses 3 response categories (hardly ever, some of the time, or often). Testing the internal consistency for the three-item revealed that it was quite good and the items reliably measure loneliness (Hughes et al, 2004).

7) Social Support: The Lubben Social Network Scale (LSNS-6)

The Lubben Social Network Scale is a twelve item instrument designed to gauge social isolation in older adults by measuring perceived social support received by family and friends. A shorter scale was devised for screening and research purposes, which was used in the quantitative survey. Three items address social support networks among family networks, and three items address social support networks for non-kin networks. Internal consistency tests reveal that both versions of the LSNS are well within the acceptable parameters for health measurement scales (Lubben & Gironde, in press). A recent report using samples from three European community-dwelling older adult populations, established a clinical cut-off of 12 or



less as suggestive of risk for social isolation (Lubben, Blozik, Gillman, Iliffe, von Renteln Kruse, Beck & Stuck, 2006).

The Qualitative Interview

For the qualitative interviews, an in-depth semi-structured interview guide was developed based on the review of the literature, our initial focus group with service providers and service users and our survey questions. The interview guide consisted of 14 questions organized under six thematic headings: 1) current living arrangements, 2) experiences of homelessness prior to being housed, 3) how people spend their time, 4) formal and informal support systems, 5) service awareness and use, and 6) finances. (Appendix C) The interviews took between one and two hours and were audio-recorded with the participant's permission.

The Focus Groups

The initial four focus groups in Toronto and Calgary explored service delivery issues to inform the content and direction of subsequent data collection. The purpose of the final two focus groups was to seek validation of our findings and recommendations for policy and practice from those service providers who participated in the first round of focus groups and from a subsection of the older adults who participated in the interviews.

Data Analysis

Description of Analysis

The creation of data files, processes for data transmission, data security and data entry for the qualitative and quantitative instruments were created for both Toronto and Calgary arms of the study.

Quantitative Data Analysis



SPSS, Version 14.0 was used to facilitate the quantitative data analysis. Descriptive statistics were used in the analysis of the quantitative survey data. Frequency distributions were produced for all variables studied. Cross-tabulations were performed to compare those housed in supportive housing to those housed in supported housing with community supports, and to compare men and women on a number of variables, as were the comparison of mean scores depending upon the level of measurement employed. Chi-square and t-tests were performed to test the statistical significance of these associations where appropriate. Testing for statistical significance was not possible in many instances because the number of cases were not sufficient to run the appropriate statistical tests. Although we were not able to run statistical comparisons between the two cities, we were able to more generally highlight the similarities and differences that were found between the two cities in our quantitative analysis.

Qualitative Data Analysis

A generic qualitative approach was used in the analysis of both the interview and focus group data. Generic qualitative research may be defined as, “that which is not guided by an explicit or established set of philosophical assumptions in the form of one of the known qualitative methodologies” (Caelli, Ray & Mill, 2003, p. 4). A generic qualitative approach was adopted in this study as it, “seeks to discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved” (Merriam, 1998, p. 11). The transcripts from the qualitative interviews and focus groups were coded, organized into emergent categories and then clustered according to central themes. Finally those themes were interpreted and a qualitative narrative, embedded with representative quotes, was produced. The second and third sets of focus groups were used to check both the credibility and trustworthiness of our data analysis.

Health Care Utilization Data Analysis

The analysis of personal health information was based on data from three Ontario databases, called: OHIP Fee-for-Service (CLSTAN), Inpatient and Day Procedure (FDASTAN) and the National Ambulatory Care Reporting System (NASTAN). The data was drawn for 136 consenting research participants, and the methodology was as follows. While



similar data was requested from Calgary, few participants agreed to consent to the release of their personal health information; therefore, the data analysis was not undertaken.

After the raw OHIP files within each health class were concatenated, the records were merged with a master file to add housing and other demographic information. Each record in the merged file contained the date on which a single health transaction occurred and the date when the homeless person acquired housing. The difference between the service date and housing date was expressed in weeks. Negative differences represented housing dates that occurred after the occurrence of a health transaction.

Data records were eliminated if the interval between a health transaction and a housing date exceeded 104 weeks, either positively or negatively. A data set was created that contained, for each person, the number of single days on which health transactions had occurred before and after the housing date.

The final data set consisted of the number of separate days that each person had received health services before that person received housing, and a matching number of separate days for health services that had been received after the housing date.

The statistical test was a paired sample t-test with a before-after structure. One outlier was removed (a single respondent) prior to running the t-tests. The null hypothesis stated that there was no difference between the mean number of days on which health services were received before and after the acquisition of housing. The null hypothesis was rejected when the probability of a difference fell below .05.

Study Limitations

The primary limitation of the study was that the sample of formerly homeless persons and service providers was not a random sample, and relied heavily on the goodwill of the service agencies. Therefore, the study results cannot be generalized, as the sample is not representative of the general formerly homeless older population. The sample is only



reflective of the client base of the referral agencies or sites where information about the study was posted and where participants self-referred to the study. A secondary limitation, related to the first, is that participation in the research process requires a fair degree of mental and physical competence. The sample, therefore, excludes very old and isolated older adults as well as those with significant mental and physical impairments, which would also be those with the greatest needs. Finally, the sample also does not reflect a diversity of ethnic, racial, cultural or linguistic difference.



SECTION 3: RESULTS OF ANALYSIS

Quantitative Data

This section presents the findings from the survey of 237 formerly homeless older adults in both Toronto (n = 201) and Calgary (n = 36). Because a truly representative sample is rarely possible, the results do not apply to all older formerly homeless people. Rather, the data are exploratory and present an approximate picture of older adults living in supportive and supported housing in the City of Toronto and the City of Calgary. Descriptive statistics are provided for the whole sample with cross tabulations by gender and housing type (supportive vs. supported: independent housing accessing community based supports) where relevant. Where helpful, some of the results from the 2004 *Homeless Older Adults Research Project* (McDonald, Dergal and Cleghorn, 2004), are presented, recognizing that the two samples are not comparable even though the 2004 Toronto survey of homeless older adults utilized many of the same questions as those in the present survey. Statistics on the health of the general population of Canadian older adults are presented where possible to compare this group with national norms for the older (65 years and over) Canadian population. Lastly, scores based on the Personal Health Information from 136 consenting housed participants examined the changes in mean days of health service utilization from pre-housing to post-housing.

Sociodemographic Profile – Toronto

Most of the 201 respondents in Toronto lived in supportive housing (71 percent) and the remainder lived in supported housing with the use of community supports. One hundred and twenty-three participants in the study were male (62 percent), seventy-six were female (38 percent),⁶ which accurately represents the ratio of men to women in the larger homeless population. The average age of the respondents was 57.09 (SD = 6.6), well over age 50, which

⁶ One participant identified their gender as “other.” When analyzing the data by gender, this case was not included in the cross tabulations.



is generally considered to be “old” for adults who have experienced homelessness. There was little difference between the average age of men (56.6; SD = 6.5) and women (57.6; SD = 6.5).

One quarter of the group was born outside of Canada, and 89 percent were Canadian citizens. Interestingly, the percentage of older adults who were immigrants to Canada in this study was similar to that of the 2004 group of homeless older adults. The majority of the respondents in the 2006 study identified their population group as “white” (69 percent), while the remainder identified themselves as Aboriginal, South Asian, or “other.”

Most of the formerly homeless adults were single (35 percent) or divorced (30 percent) at the time of the interview. More men than women were single (42 percent vs. 25 percent), while more women were widowed than men (21 percent vs. 10 percent). One third of the group had attended university or college (35 percent), while 55 percent had some high school education or had completed high school. For more detail, see Table 1.

Sociodemographic Profile - Calgary

Most of the 36 respondents lived in supported or housing with the use of community supports (58 percent) and the remainder lived in supportive housing (42 percent). Twenty-nine participants in the study were male (81 percent), and 7 were female (19 percent). The average age of the respondents was 57.22 (SD = 5.64), well over age 50, which is generally considered to be “old” for adults who have experienced homelessness. There was little difference between the average age of men (56.9; SD = 5.7) and women (58.4; SD = 5.41).

Eleven percent of the group were born outside of Canada, and 89 percent were born in Canada. The majority of the respondents in the 2006 study identified their population group as “white” (83 percent), while the remainder identified themselves as Aboriginal. Most of the formerly homeless adults were divorced (50 percent) or single (28 percent) at the time of the interview. Twenty-eight percent of the group had attended university or college, while 59 percent had some high school education or had completed high school. See Table 1.



Table 1: Sociodemographic Profile		
	TORONTO	CALGARY
	Total Percent (N)	Total Percent (N)
Gender		
Male	62 (123)	81 (29)
Female	38 (76)	19 (7)
Other	1 (1)	---
Age		
Mean	57.09	57.22
Standard Deviation	6.63	5.64
Marital Status		
Single	35 (71)	28 (10)
Now married	5 (10)	3 (1)
Common law marriage	3 (6)	----
Separated	12 (24)	14 (5)
Divorced	30 (60)	50 (18)
Widowed	15 (29)	6 (2)
Born in Canada		
No	24 (46)	11 (4)
Yes	76 (148)	89 (32)
Population Group		
Aboriginal	9 (17)	17 (6)
Black	7 (13)	----
Chinese	1 (1)	----
Latin American	1 (1)	----
South Asian	8 (15)	----
East Asian	1 (1)	----
White	69 (138)	83 (30)
Education		
No schooling	1 (1)	----
Some elementary (grades 0-8)	4 (7)	11 (4)
Completed elementary (grade 8)	6 (11)	3 (1)
Some high school (grades 9-12 or 13)	35 (70)	31 (11)
Completed high school (grade 12 or 13)	20 (39)	28 (10)
Some trade, technical, college, business school	8 (16)	8 (3)
Completed diploma/certificate	8.5 (17)	3 (1)
Some university	7 (13)	6 (2)
Completed university degree	7 (14)	8 (3)
Masters or doctorate	3 (5)	3 (1)
Other	5 (3)	----
Housing Type		
Supportive housing	71 (143)	42 (15)
Supported housing with community supports	29 (58)	58 (21)



Experience of Homelessness

The Toronto group was in agreement that homeless people begin to experience aging sooner than other adults, at around age 45. This is five years younger than most of the literature on homelessness suggests, which identifies age 50 as “old” for homeless adults. The Calgary group, however, was in agreement with the literature, citing age 51. The average age when the participants first became homeless was 40 in Toronto, with a wide range of variation ($SD = 14.9$) while the average age at which Calgary participants became homeless was older, at 45 with a wide range of variation ($SD = 14.8$).

The homeless histories that emerged from the survey indicated that the majority of participants had been homeless more than once in both cities (60 percent of Toronto participants, 56 percent of Calgary participants). Men reported significantly more homeless episodes than women in both cities. The Toronto group had an average of 4.5 episodes of homelessness ($SD = 7.3$) and the Calgary group had an average of 5.7 episodes of homelessness ($SD = 17.2$). In their last episode of homelessness, one half of the Toronto participants (51 percent) and more than three quarters of the Calgary participants (78 percent) were homeless for less than 1 year. Twenty-eight percent of the Toronto participants were homeless for 1 to 3 years, 4 percent were homeless for 3 to 5 years and the remaining 17 percent were homeless for 5 years or more. In Calgary, 14 were homeless for 1 to 3 years, 5 percent were homeless for 3 to 5 years and the remaining 3 percent were homeless for 5 years or more. The majority of participants in both cities had stayed at a shelter (87 percent in Toronto, 90 percent in Calgary) at some time during their experience of homelessness. When gender was considered, the men were typically homeless for longer than the women: the last episode of homelessness was an average of 3.3 years for men versus 2.3 years for women in Toronto. In Calgary a different pattern emerged, because the last episode of homelessness was shorter for both men and women: an average of one year for men versus three months for women. This shorter time frame would suggest that providing housing in Calgary occurred more quickly.



Housing History

Finding Current Housing

In Toronto, of the 71 percent (n = 142) of respondents living in supportive housing and the remaining 29 percent (n = 59) living in independent housing with community supports, most (50.5 percent) had been housed for 5 years or more. Another 30 percent had been housed for 1 to 3 years, and 19 percent had housing for less than 1 year. Over one half (58 percent) found their current residence with help from a housing worker, 10 percent reported help from shelter staff, and the rest found their housing themselves.

In Calgary, of the 42 percent (n= 15) of respondents living in supportive housing and the remaining 58 percent (n = 21) living in independent housing with community supports, most (55 percent) had been housed for less than one year (n = 20). Another 33 percent had been housed for 1 to 3 years, and only 8 percent had housing for 5 years or more. Approximately 47 percent found their current residence with help from a housing worker, 6 percent reported help from shelter staff, 12 percent reported finding their housing themselves, and 19 percent indicated they used other means to find their housing.

Current Housing Arrangement

In Toronto, sixty-four percent of tenants shared rooms, such as the kitchen, bathroom and common area in their apartments, and most of those who shared rooms were housed in supportive housing rather than living in independent housing (72 percent vs. 48 percent). The majority of tenants in both types of housing found their housing “somewhat” or “very” affordable.

In Calgary, eighty-six percent of tenants shared rooms, such as the kitchen, bathroom and common area in their apartments, and most of those who shared rooms were housed in supportive housing rather than living in independent housing (61 percent vs. 39 percent).

Adequacy and Accessibility of Housing



The tenants in both cities and both types of housing were generally satisfied with the physical space, privacy and cleanliness of their apartments. However, one third of the Toronto group reported “fair” or “poor” air quality and noise. Air quality was reportedly a greater problem for those living in independent housing, but no other differences were remarkable between the two types of housing. A similar picture emerged for Calgary, but here the people living in supported or independent housing were more likely to report the air quality, cleanliness, physical space and privacy of their home as fair or poor compared to those living in a supportive housing environment. (see Table 2). This may partially be reflected by the fact that one of the supportive housing facilities from which many of the participants were recruited was less than one year old and had been designed to meet the needs of the targeted older population.

When asked about whether the residences were equipped to assist people with impaired mobility (e.g. grab bars, ramps, wider doorways, etc.), the overwhelming majority of Toronto respondents noted that the buildings and units were not equipped for these purposes. The implications of this finding are serious. As the tenants age and possibly experience problems with mobility, the units will not be able to accommodate these needs and the tenants will be forced to move. In Calgary, the situation was completely different with the majority of respondents indicating that their residences were equipped to assist people with impaired mobility. This, again, may reflect the recent building of one of the supportive housing residences from which participants were recruited or, more generally, the younger housing stock that exists in Calgary as compared with Toronto. Calgary supportive housing was more sensitive to the needs of older adults because it was specifically built for older persons who obviously appreciated the modifications.



Table 2: Adequacy of Housing by Housing Type						
	Housing Type					
Air quality	Supportive Housing		Supported Hsg (w/ comm. supports)		Total	
	Toronto	Calgary	Toronto	Calgary	Toronto	Calgary
Excellent	10 (14)	7 (1)	10 (6)	5 (1)	10 (20)	6 (2)
Very good	19 (27)	13 (2)	15 (9)	10 (2)	18 (36)	11 (4)
Good	34 (48)	40 (6)	41 (24)	14 (3)	36 (72)	25 (9)
Fair	21 (30)	40 (6)	25 (15)	38 (8)	22 (45)	39 (14)
Poor	16 (23)	---	9 (5)	33 (7)	14 (28)	19 (7)
Cleanliness						
Excellent	17 (25)	20 (3)	14 (8)	14 (3)	16 (33)	17 (6)
Very good	25 (35)	40 (6)	25 (15)	14 (3)	25 (50)	25 (9)
Good	34 (48)	27 (4)	42 (25)	24 (5)	37 (73)	25 (9)
Fair	12 (17)	13 (2)	14 (8)	38 (8)	12 (25)	28 (10)
Poor	12 (17)	---	5 (3)	10 (2)	10 (20)	6 (2)
Noise						
Excellent	16 (22)	20 (3)	10 (6)	5 (1)	14 (28)	11 (4)
Very good	22 (31)	33 (5)	17 (10)	24 (5)	20 (41)	28 (10)
Good	30 (43)	27 (4)	39 (23)	52 (11)	33 (66)	42 (15)
Fair	14 (20)	20 (3)	17 (10)	19 (4)	15 (30)	19 (17)
Poor	18 (26)	---	17 (10)	---	18 (36)	---
Physical Space						
Excellent	15 (21)	20 (3)	14 (8)	10 (2)	14 (29)	14 (5)
Very good	29 (42)	---	14 (8)	---	25 (50)	---
Good	33 (47)	47 (7)	55 (32)	33 (7)	39 (79)	39 (14)
Fair	12 (17)	27 (4)	12 (7)	43 (9)	12 (24)	36 (13)
Poor	11 (15)	7 (1)	7 (4)	14 (3)	10 (19)	11 (4)
Privacy						
Excellent	21 (30)	27 (4)	20 (12)	19 (4)	21 (42)	22 (8)
Very good	26 (37)	13 (2)	17 (10)	24 (5)	23 (47)	19 (7)
Good	33 (46)	53 (8)	49 (29)	38 (8)	37 (75)	44 (16)
Fair	11 (16)	---	5 (3)	10 (2)	10 (19)	6 (2)
Poor	9 (13)	7 (1)	9 (5)	10 (2)	9 (18)	8 (3)



Building Security and Safety

Twenty-two percent of tenants in Toronto and 17 percent of tenants in Calgary said they did not feel safe in their building, with no differences according to gender or type of housing. In Toronto, the majority of the occupants of supportive housing cited criminal activity in the area and fellow tenants as the main reasons for feeling unsafe, whereas the responses from adults living in supported housing were more varied, and included criminal activity, the presence of guests, other tenants and inadequate security. A similar picture emerged in Calgary. People living in supported housing cited other people in the building, people living near the building and criminal activity as their main reason for feeling unsafe, while people living in supportive housing cited people living in the building and criminal activity in the area as their reasons for feeling unsafe.

Building security and personal safety emerged as major topics in the qualitative interviews. On the one hand, tenants wanted to be able to have guests, but visitors also stirred suspicion and fear in fellow tenants. The majority of Toronto tenants were permitted to have guests visit in the day, while one quarter were not permitted to have guests overnight. A small percentage had to obtain permission from staff for daytime guests, and a larger percentage had to do the same for overnight guests (17 vs. 46 percent). In Calgary a similar picture emerged, with the majority of tenants being permitted to have visits during the day, but three quarters were not permitted to have overnight guests. As in Toronto, a small percentage had to obtain permission from staff for daytime guests, and a larger percentage had to do the same for overnight guests (20 vs. 27 percent).

Linked Services

The respondents were asked to report on the various kinds of support and services that were available where they lived (see Table 3). The most common health services offered in Toronto were medical care (43 percent), case work (42 percent), medication management (26 percent), and homecare (26 percent), followed by mental health and addiction services (20 percent). A very similar picture emerged in Calgary, with the most common health services



offered being medical care (64 percent), case work (50 percent), medication management (42 percent), foot care (39 percent) mental health and addiction services (33 percent), followed by homecare (28 percent).

Table 3: Availability of Health Services*		
	TORONTO	CALGARY
	Percent (N)	Percent (N)
Health Services offered where you live		
Medical care	43 (82)	64 (23)
Dental care	4 (7)	11 (4)
Foot care	13 (24)	39 (14)
Eye care	4 (7)	11 (4)
Mental health and addiction services	20 (38)	33 (12)
Case work	42 (80)	50 (18)
Physiotherapy	5 (10)	8 (3)
Diet/nutrition services	18 (9)	22 (8)
Medication management	26 (50)	42 (5)
Homecare	26 (49)	28 (10)
Other health services	7 (14)	8 (3)
Don't know	3 (5)	3 (1)
Not applicable	26 (50)	14 (5)

*This is a multiple response question; therefore, the percentages represent the proportion of people who responded to each category and will not add up to 100 percent.

Given the opportunity to list health services that they wished were available but were not, the tenants' answers in both Toronto and Calgary did not reveal one medical service desired over another. Instead, the responses were quite evenly distributed across all categories of health services not offered but desired, such as medical care, dental, foot and eye care, mental health and addiction services, diet/nutrition, homecare and physiotherapy.

The tenants were asked about other forms of supports offered in their buildings (see Table 4). In Toronto, tenant committees (65 percent), assistance completing forms (61 percent), and referrals to services (49 percent) were cited most often. In Calgary, a similar but slightly different picture emerged with assistance completing forms (69 percent), referrals to services (53 percent), and advocacy (39 percent) being the most often cited. Although not



reported in Table 4, when asked about the types of supports they wished were available, the participants' responses in Toronto did reveal agreement about the need for additional forms of support, such as transportation services (31 percent), special services for older people (26 percent) and skills development (22 percent). Calgary varied somewhat, with advocacy services (38 percent), skills development (25 percent) and special services for older people (22 percent) being identified as additional supports that they desired. The differences reflect what was *not* as liberally offered in each site.

Table 4: Availability of Supports*		
	TORONTO	CALGARY
	Percent (N)	Percent (N)
Supports available where you live		
Assistance completing forms	61 (119)	69 (25)
Advocacy	32 (62)	39 (14)
Skills development	26 (51)	33 (12)
Transportation	22 (42)	33 (12)
Tenant committees	65 (126)	28 (10)
Referrals	49 (95)	53 (19)
Ethnocultural services	11 (22)	19 (7)
Specific Services for older people	24 (47)	22 (8)
Other	6 (11)	8 (3)
Don't know	2 (4)	6 (2)
Not applicable	14 (28)	14 (5)

*This is a multiple response question; therefore, the percentages represent the proportion of people who responded to each category and will not add up to 100 percent.

The formerly homeless adults also listed the amenities received from the housing provider, and the most common in Toronto were meal services (42 percent), housekeeping services (39 percent), and social/recreational services (39 percent). In a breakdown of the social/recreational services available, the older adults listed special events (50 percent), day trips (40 percent), arts and crafts (39 percent), and games (37 percent) as the most common. A small number of respondents wanted to see increased availability of meal services and social/recreational services.



In Calgary, the most commonly cited amenities received were meal services (86 percent), housekeeping services (53 percent), religious services (39 percent) and social/recreational services (36 percent). In a breakdown of the social/recreational services available, the older adults listed exercise programs (31 percent), games (19 percent, and arts and crafts (19 percent). A large number of Calgary respondents wanted more social/recreational programs (41 percent), followed by religious programming (22 percent) and laundry services (7 percent).

Meals

In Toronto, the majority of formerly homeless older adults living in both types of housing made their own meals. When they cooked for themselves, the tenants most often bought their own groceries, but 42 percent reported using a food bank for groceries. Some participants indicated that they also attended meal programs outside the building or ate in a congregate dining room for lunch and dinner. The majority of respondents enjoyed the meals provided in the congregate dining room and confirmed that a good variety of foods were available that reflected the ethno-cultural preferences of the tenants. Less favourable was the dietary value of the meals, where 46 percent of respondents rated the satisfaction of dietary needs as “fair” or “poor.” The majority of participants (84 percent) reported having enough to eat. For those who reported not having enough to eat, the main cause cited was: “cannot afford.”

In Calgary, the majority of formerly homeless older adults living in supportive housing ate in congregate dining facilities. A number of participants in both types of housing indicated that they also attended meal programs outside the building. Many respondents indicated they did not enjoy the meals, rating them as fair or poor (50 percent). The dietary value of the meals, were also not rated favourably where 36 percent of respondents rated the satisfaction of dietary needs as “fair” or “poor.” The majority of participants (83 percent) reported having enough to eat. For those who reported not having enough to eat, the main causes cited were: cannot afford and do not have the appropriate facilities to prepare food.



Social Interactions in the Residences

Tenants in both Toronto and Calgary were generally satisfied with their interactions with the housing staff, and the majority favourably ranked the confidence they had in the staff, the support available, the concern conveyed by the staff, and the independence encouraged by the staff. Similarly, most of the tenants reported favourable interactions with tenants both one-on-one and in group events, while approximately one quarter rated the interactions as “fair” or “poor.” As for the frequency of social interactions in Toronto, 85 percent of tenants initiated one-on-one interactions at least once a week, and 53 percent interacted in a group setting at least every week. In Calgary, 70 percent of tenants initiated one-on-one interactions at least once a week, and 55 percent interacted in a group setting at least every week.

Health Care and Health Status of Formerly Homeless Older Adults

Use of Health Care Services

In Toronto, the majority of older adults in the study had a health card (94 percent). In Calgary, fewer respondents had a health card (86 percent) perhaps because they have to make monthly payments. In the last six months, the majority of respondents in Toronto received care from the following medical professionals: 85 percent visited their general practitioner, one third saw a social worker, and 28 percent consulted with a psychiatrist or psychologist. In the last six months, the majority of Calgary respondents received care from the following medical professionals: 53 percent visited their general practitioner, 47 percent saw a social worker, and 17 percent consulted with a psychiatrist or psychologist. The Calgary group appeared to have slightly less access to a personal physician, a problem apparently facing many Calgarians.

As for where the participants received medical care in the last six months, two-thirds of participants in Toronto received care from a private doctor’s office, 41 percent visited the emergency room, 35 percent went to a clinic, and 25 percent utilized a community health centre (CHC). As for where the Calgary participants received medical care in the last six months, 47 percent of participants received care from a private doctor’s office, 42 percent



visited the emergency room, and 33 percent went to a clinic or a community health centre (CHC).

Table 5: Use of Medical Services*		
	TORONTO	CALGARY
	Percent (N)	Percent (N)
In the past six months, locations where participants have received medical care ...		
A hospital where you stayed at least 1 night	23 (43)	33 (12)
Hospital emergency room	41 (76)	42 (15)
Hospital outpatient clinic	35 (64)	33 (12)
Drop-in center	22 (41)	14 (5)
Community health center	25 (46)	33 (12)
Walk-in clinic	27 (50)	33 (12)
Private doctor's office	62 (114)	47 (17)
Addiction treatment/unity center	12 (22)	11 (4)
At home	5 (9)	17 (6)
Other	3 (6)	----

*This is a multiple response question; therefore, the percentages represent the proportion of people who responded to each category and will not add up to 100 percent.

In Toronto, when the use of medical services is compared according to housing type, those housed in supported housing with community supports reported consistently higher percentages of use than those in supportive housing. Participants in supported housing used more medical services at hospitals, walk-in clinics and doctor's offices, and made significantly more use of medical services at drop-ins (36 percent vs. 14 percent). The only medical services that supportive housing tenants' used more of was addiction treatment (13 percent) and medical services "at home."

Calgary was similar to Toronto in that when the use of medical services is compared according to housing type; those housed in supported housing with community supports reported consistently higher percentages of usage than those in supportive housing. Calgary participants in independent housing used more medical services at hospitals, emergency rooms, drop-in centres, or at a private doctor's office, and made significantly more use of medical services at community health centres (22 percent vs. 11 percent) and walk-in clinics



(25 percent versus 8 percent). The only medical services that supportive housing tenants' used more were medical services delivered at home.

In Toronto, twenty-three percent of respondents said that they had difficulty accessing health care when they needed it, mostly because the waiting time was too long or there were problems with transportation. Similar findings were true for the older homeless group in the 2004 study. Similarly in Calgary, 17 percent of respondents said that they had difficulty accessing health care when they needed it, mostly because the waiting time was too long or they felt the care would be inadequate. There were also problems identified with transportation, not knowing where to go for help, or affordability.

Use of Health Services Before and After Housing

In Table 6, scores were compared using two-tailed paired t-tests that examined the changes in mean days of health utilization from pre-housing to post-housing. The number of separate days that each person had received fee-for-service (doctor visits), use of ambulatory care (emergency room) and in-patient/day patient health services before he or she was housed was matched with the number of separate days for these services received after the housing date. As noted earlier, data records were eliminated if the interval between a health transaction and a housing date exceeded 104 weeks, either positively or negatively. The Calgary data did not meet these criteria because the housed had entered a new facility that was less than one year old. In Toronto the analyses was based on the Personal Health Information of 136 consenting housed participants who were previously interviewed in the survey.

The findings indicated that there was no significant change from pre-test to post-test for fee-for-service, $t(108)=1.93$, *n.s.* but there was a significant decrease in the mean days of emergency room use, $t(50)=-1.99$, $p\leq .000$ and the mean days for in-patient/day patient care $t(46)=3.75$, $p\leq .001$. Even though 40 percent of the respondents reported that they had used an emergency room in the last 6 months in the survey, the actual mean number of visits dropped significantly after being housed as did in-patient and day-patient care. The changes



suggest that housing may contribute to more stable health care for the homeless once they are housed. The changes also imply reductions in the cost of care for this group as a result of being housed since ambulatory care and in-patient care are expensive health services. Also, these findings are consistent with the survey findings that the health of the newly housed was improved compared to earlier studies of the homeless although below that for the general population in this age group. It is important to note, however, that the results have to be interpreted with some caution. The design problem with a simple pre-test post-test design is that it does not control for other variables that might explain the observed differences in mean days of health utilization. Regression analyses will be done in the future controlling for such factors as age, gender, length of homelessness marital status and income to try to isolate the effects of being housed on health utilization.

Table 6: Paired Samples for Days Used for Health Services					
Health Service Received	Mean No. Days Received Health Service	Standard Deviation	N	t	<i>P</i> 2-tailed
Fee-for-Service					
Before Housing	25.62	25.19	109	1.933	.056
After Housing	19.54	33.30	109		
Emergency Care					
Before Housing	9.69	3.15	51	1.995*	.000
After Housing	1.31	5.89	51		
In-Patient/Day Patient Procedure					
Before Housing	1.34	.700	47	3.745*	.001
After Housing	.57	1.57	47		

*indicates statistical significance at $p \leq .05$



Health Status

The group's self-reported health status revealed that only 18 percent of the formerly homeless older adults considered their health to be "very good" or "excellent," while 50 percent considered it to be "fair" or "poor." Calgary had similar findings, with only 22 percent of the formerly homeless older adults considering their health to be "very good" or "excellent," while 53 percent considered it to be "fair" or "poor." There were slight differences when the responses for women and men were compared, where more women rated their health as "good" and more men rated their health as "fair" (see Chart 1a). In Calgary, women were more likely to report their health as "excellent" while men were more likely to report their health as "poor" (See Chart 1b). These ratings are lower when compared to percentages for Canadians age 65 and over, where more older adults considered their health to be "very good" or "excellent" (40 percent), or "fair" or "poor" (22 percent) (Statistics Canada, 1999).

Typically, older men reported better health than women, but here there was little difference between the self-reported health of formerly homeless men and women. There was also little difference between the self-reported health of this group and the 2004 homeless group; there was only a slightly greater number of homeless older adults who reported being in "fair" rather than "good" condition.



Chart 1a: Health Status of Formerly Homeless Men and Women - Toronto

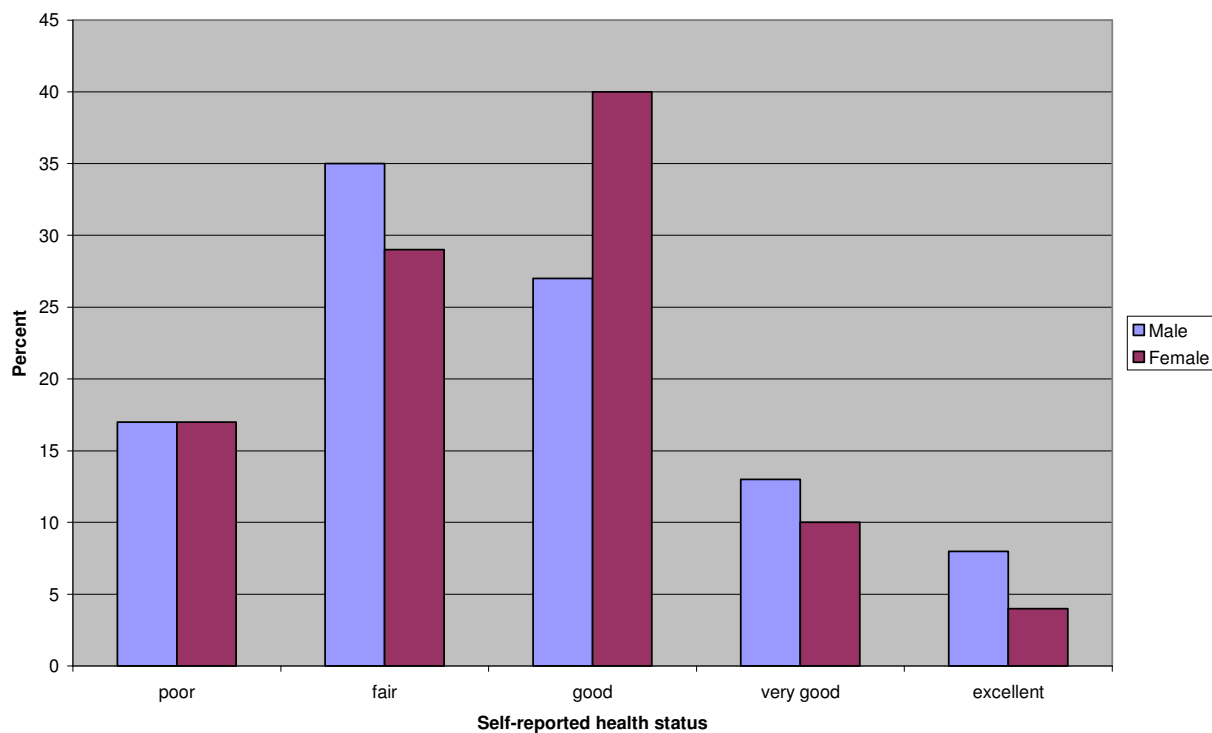
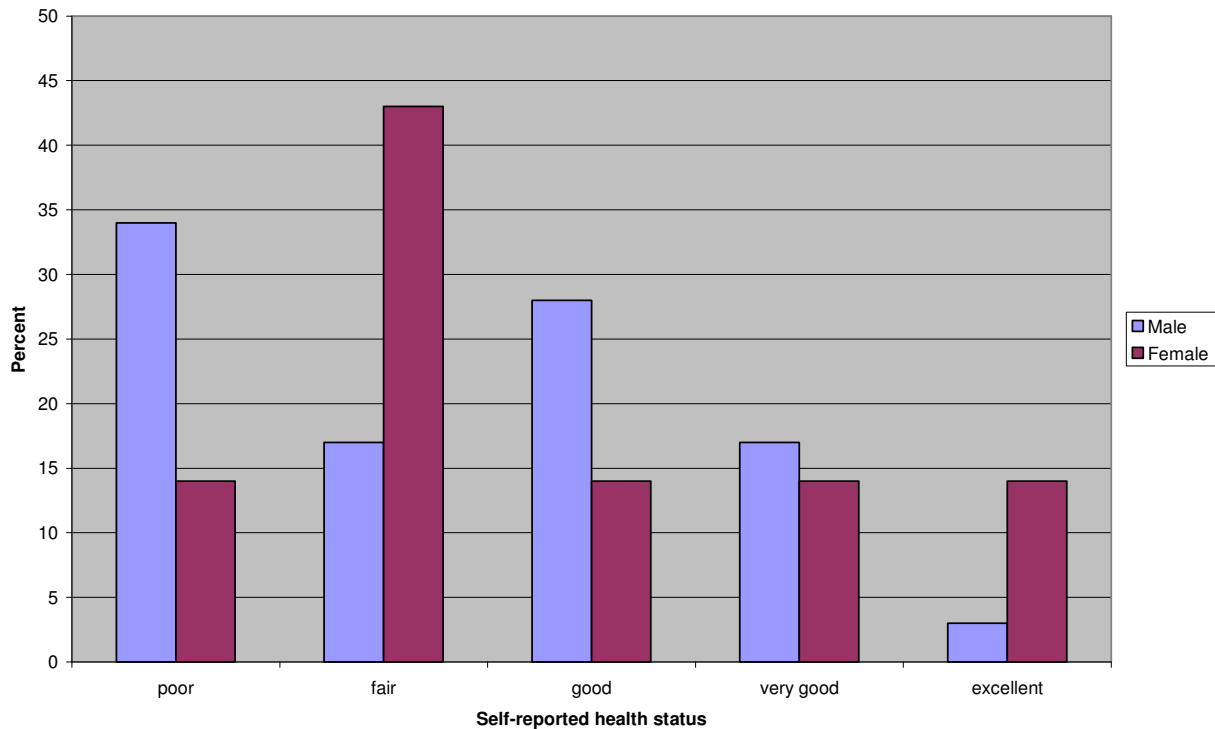


Chart 1b: Health Status of Formerly Homeless Men and Women - Calgary



Short-form 12 (SF-12) Health Status Survey

The SF-12 is a widely used multipurpose short-form (SF) measure of health status with two summary scales: a Physical Component Summary (SF-12 PCS) scale and a Mental Component Summary (SF-12 MCS) scale. Although the scores cannot be directly compared, there is some suggestion that the scores for the formerly homeless in Toronto were generally higher than those for the 2004 Toronto homeless group but still lower than norms for the general population.

The formerly homeless adults in Toronto had a mean SF-12 PCS score of 42.04 (SD = 12.07) and a mean SF-12 MCS score of 44.40 (SD = 12.68). The formerly homeless in Calgary had different results with a mean physical component summary (SF-12 PCS) score of 39.49 (SD = 11.33) and a mean mental component summary (SF-12 MCS) score of 45.50 (SD = 12.65). That the formerly homeless in Toronto have a slightly lower mental component



score than those in Calgary may be explained by the fact that the Toronto group have experienced more persistent homelessness and took longer to find housing. On the other hand, the poorer physical health of the Calgary group may be attributable to a number of factors, not the least of which, might be the fact that fewer have health cards and/or the shortage of general family practitioners in Calgary making access to care more difficult. However, both sets of the summary scores were below the norms for the general U.S. population; namely, a mean of 46.55 for the SF-12 PCS and 50.57 for the SF-12 MCS for those aged 55-64. The mean summary scores for the formerly homeless group were also somewhat lower than the U.S. norms for the age group 65-74 with means of 43.65 for the SF-12 PCS and 52.10 for the SF-12 MCS.

There was a significant difference in the SF-12 PCS – physical component – scores for men and women in Toronto only. Men had significantly higher scores on the SF-12 PCS than women: males had a mean of 44.28 (SD = 11.63) and females, a mean of 38.34 (SD = 11.96). No significant differences between men and women were evident in the scores for the SF-12 MCS – mental component. There was also a significant difference for SF-12 PCS scores, but not for SF-12 MCS scores, between those living in supportive housing versus supported housing with community-based supports. There was a significantly higher average physical health score for those living in housing with onsite supports.

Table 7: Comparison of SF Scores*			
	2006 Group Toronto	2006 Group Calgary	Gen. Pop. age 65-74
SF-12 physical component			
Mean	42.04	39.49	43.65
Standard deviation	12.07	11.33	11.02
Sf-12 mental component			
Mean	44.40	45.50	52.10
Standard deviation	12.68	12.65	9.53



Activities of Daily Living (ADL)

Activities of daily living (ADL) were assessed to determine whether the person required help with walking, bathing, grooming, dressing, eating, and going to the bathroom. While the findings above indicated a relatively poor health status for this group, only six percent of the formerly homeless older adults in Toronto reported needing help with their activities of daily living. In Calgary, slightly more respondents indicated needing help with their activities of daily living (14 percent), perhaps because their self-rated health was somewhat worse.

Reported Health Problems

The top reported health problems of the formerly homeless older adults in Toronto were vision problems (63 percent), teeth or gum problems (45 percent), back problems (44 percent), arthritis /rheumatism (46 percent), depression (37 percent), nerves or anxiety (37 percent), and blood pressure (34 percent). Back problems and trouble with nerves and anxiety were more commonly cited by women, as were many of the other reported health problems like migraines, bi-polar disorders, diabetes, and asthma.

Calgary had similar findings. The top reported health problems of the formerly homeless older adults in Calgary were vision problems (58 percent), back problems (47 percent), arthritis /rheumatism (44 percent), depression (39 percent), nerves or anxiety (28 percent), teeth or gum problems (55 percent), and blood pressure (25 percent).

In the general population, the top three chronic conditions for adults aged 65 and over are similar: arthritis/rheumatism (47 percent), cataracts/glaucoma (25 percent), and back problems (24 percent). After the top three chronic conditions the findings vary, where heart disease (20 percent), diabetes (14 percent), thyroid condition (13 percent) and urinary incontinence (11 percent) figure as the next most common chronic conditions for the Canadian population (Gilmour & Park, 2003).



Prescription Medication

Seventy-seven percent of the formerly homeless older adults in Toronto were supposed to be taking prescription medication, and nearly half said that they sometimes forgot. The majority were responsible for keeping and distributing their own medication, but 20 percent had housing/health care workers or a friend pick up their prescriptions.

In Calgary, seventy percent of the formerly homeless older adults in Toronto were supposed to be taking prescription medication, and nearly 28 percent said that they sometimes forgot. The majority were responsible for keeping and distributing their medication, but six percent had housing/health care workers or a friend pick up the prescription for them.

Mental Health Status

As with the homeless population, the Toronto group reported greater difficulties with depression and anxiety than older adults in the general population. The participants were asked a series of questions about the way they felt about their lives, which was part of the Geriatric Depression Scale (GDS). The scale established that two-thirds of the housed Toronto group were not depressed, but almost one quarter (24 percent) were experiencing “possible depression,” and 9 percent were “probably depressed.” In Calgary, 31 percent of the group were not depressed, but more than half (56 percent) was experiencing “possible depression,” and 24 percent were “probably depressed.” In the general Canadian population of older adults age 55-64, 5.4 percent showed symptoms of “probable depression” and 2.6 showed “possible depression.” The rates were lower for adults aged 65 and over, where 3.2 percent scored in the range of “probable depression” and 2.2 in the range of “possible depression” (Statistics Canada, 2000/01). Also, women were almost twice as likely to have higher rates of depression and to seek help for depression compared to men. In the 2006 group, there was a significant difference between the depression rates for women and men.



Memory

In Toronto, the formerly homeless had some memory problems as determined by the Orientation-Memory Concentration Test. Thirty-two percent of the formerly homeless older adults in Toronto tested in the range of memory problems. Within the thirty-two percent of formerly homeless older adults with memory problems, more were male than female. The type of housing was not associated with poorer memory, since those participants scoring in the range of memory problems were equally distributed between supportive and supported types of housing. Slightly higher percentages were found in Calgary, with 50 percent of the formerly homeless older adults testing in the range of memory problems.

Alcohol and Tobacco Use

The formerly homeless adults were administered the CAGE questionnaire, which establishes evidence of problem drinking. More than half of the formerly homeless participants in Toronto indicated that they did not drink at all, as did 64 percent of the Calgary participants. Of those who indicated that they currently drank alcohol, 35 percent of the Toronto adults had scores that indicated problem drinking. Of those 35 percent, 71 percent were men and 29 percent were women. In Calgary, 25 percent of the formerly homeless older adults had CAGE scores that indicated problem drinking. In the general population age 55 to 64, probable alcohol dependence is detected in 1.8 percent of the population and this percentage drops in the older age groups, according to the Canadian Community Health Survey (Statistics Canada, 2000/01). Sixty-seven percent of all participants in Toronto and 44 percent of all participants in Calgary reported smoking tobacco.

Personal Safety

The formerly homeless report much fewer violations of personal safety than homeless older adults in other studies, which would have a significant impact on the older adults' physical and mental well-being. Sixteen percent of the Toronto sample reported experiences of robbery, nine percent reported physical assault and two percent reported sexual assault in



the last six months. In Calgary, 17 percent reported experiences of robbery, 8 percent reported being physically assaulted and 3 percent reported sexual assault.

Life Satisfaction

Fifty-nine percent of the participants in Toronto reported feeling satisfied with their life, with negligible differences between women and men (see Chart 2a). Calgary had similar findings, with 47 percent reporting feeling satisfied with their lives (see Chart 2b). Rates of life satisfaction are higher in the general population, where 89 percent of men and women age 65 and over report satisfaction with their lives (Statistics Canada, 2002).

Chart 2a: Level of Satisfaction of Formerly Homeless Men and Women - Toronto

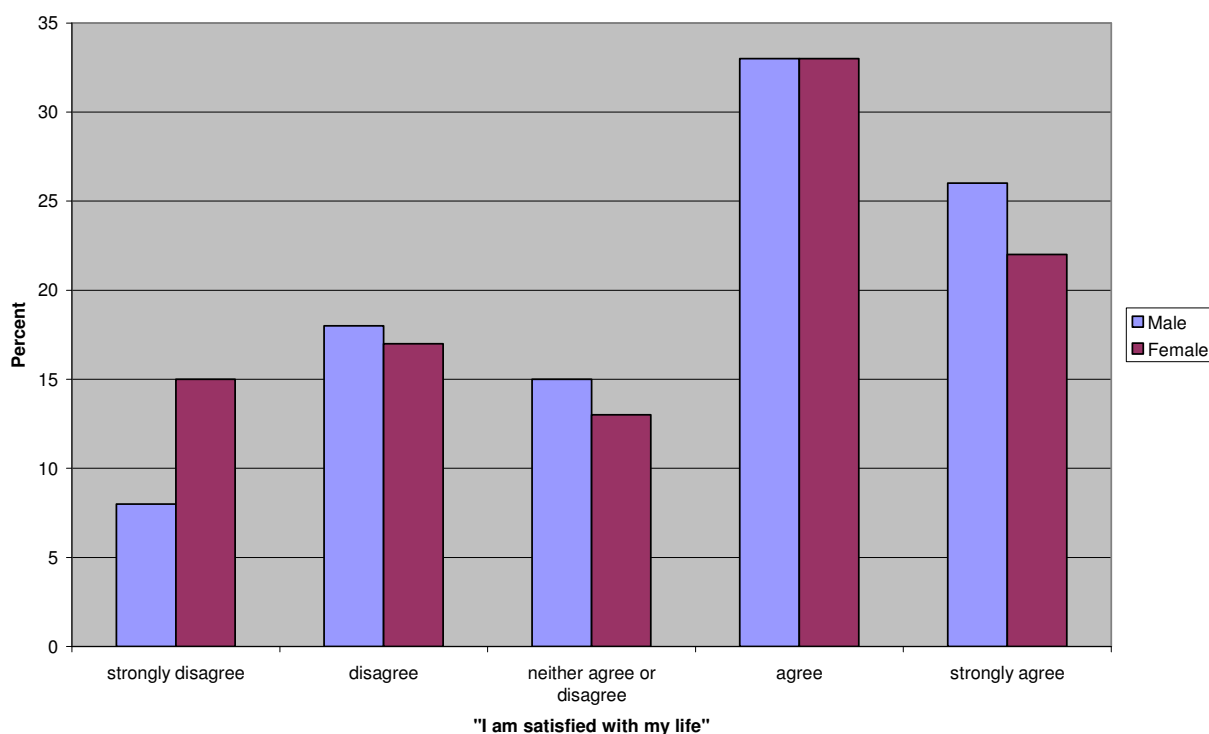
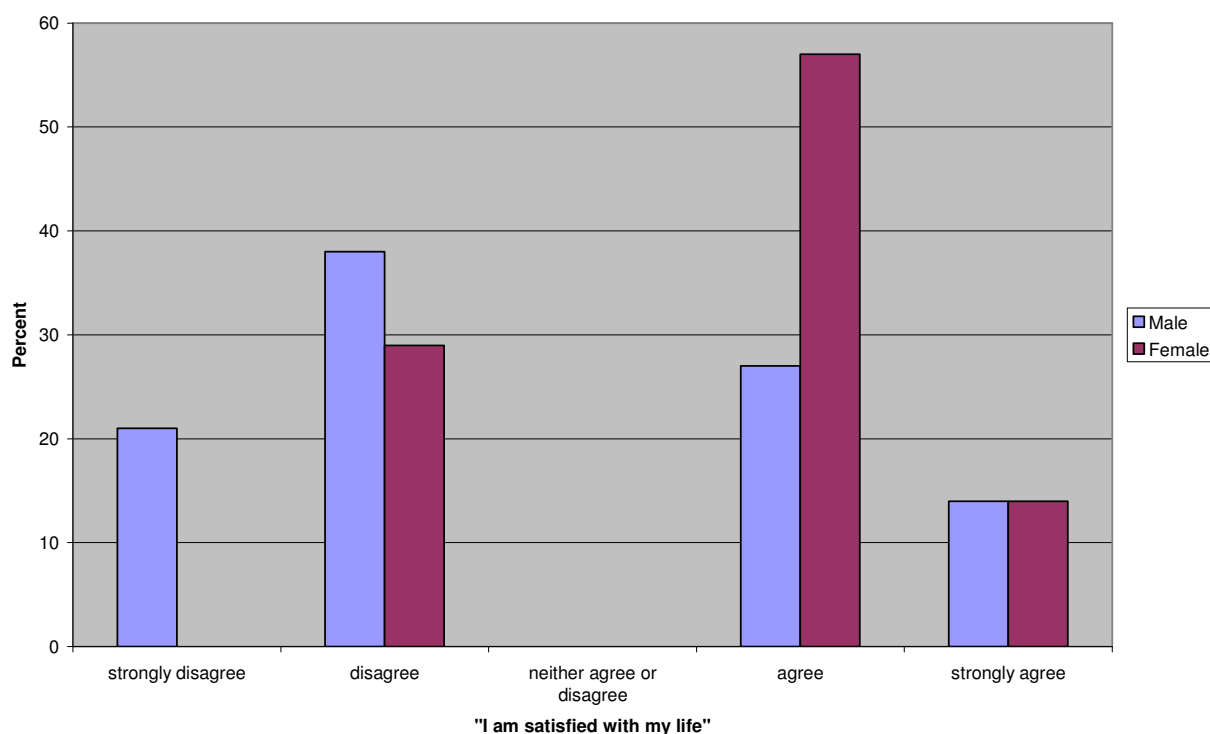


Chart 2b: Level of Satisfaction of Formerly Homeless Men and Women - Calgary



Community Services

Table 8 indicates the percentage of community services used by formerly homeless older adults in the last six months. In Toronto, health services were the most frequently used (61 percent), followed by drop-in centres, food banks or meal programs, the library, and places of worship. Notably, this group relied greatly upon food banks, meal programs and drop-ins to get a meal, a sign of the depth of poverty experienced by most formerly homeless older adults. When gender is compared, there were slight differences. The women's top ranked community service was health care, while men reported using drop-ins for meals more often. Women frequented places of worship more often than men, while more men than women used employment services. Similarly in Calgary, health services were the most frequently used (58 percent), followed by the library, drop-in centres, food banks or meal programs, and places of worship. Like the Toronto group, this group relied greatly upon food banks, meal programs and drop-ins to get a meal, also a sign of the depth of poverty experienced in a smaller city.



Table 8: Use of Community Services*		
	TORONTO	CALGARY
	Percent (N)	Percent (N)
Used the Following Services in the Past Six Months . . .		
Drop-ins to socialize	59 (112)	31 (11)
Drop-ins to get a meal	58 (111)	42 (15)
Meal program/food bank	46 (88)	25 (9)
Community centre	18 (35)	3 (1)
Health service	64 (123)	58 (21)
Mental health service	21 (40)	11 (4)
Church, mosque or temple	40 (77)	22 (8)
Legal service	14 (27)	14 (5)
Advocacy service	9 (18)	8 (3)
Addiction service	14 (26)	11 (4)
Special services for older people	6 (12)	----
Ethno-specific organization	14 (26)	6 (2)
Mediation Services	9 (11)	3 (1)
Employment service or program	18 (34)	17 (6)
Library	49 (93)	58 (21)
Educational program	12 (23)	14 (5)

*This is a multiple response question; therefore, the percentages represent the proportion of people who responded to each category and will not add up to 100 percent.

Social Support

Family

The participants were asked about their family members and whether they had contact with them in the previous month. The formerly homeless in Toronto reported that the most frequent contact was with siblings (48 percent), children (39 percent), and “other” extended family members (32 percent). Of the 32 percent of men and women who had grandchildren, 20 percent saw their grandchildren in the month prior to the interview. The formerly homeless in Calgary reported the most frequent contact was with their spouses (89 percent) “other” extended family members (73 percent), children (55 percent), and siblings (31 percent). Of the



34 percent of men and women who had grandchildren, 25 percent saw their grandchildren in the month prior to the interview.

Social Isolation and Social Networks

The research participants provided responses to a short version of the UCLA Loneliness Scale, where loneliness is understood as more than being alone, but includes feelings of isolation, disconnectedness, and not belonging. A higher score indicates greater loneliness, with a maximum score of 9. The mean for the Toronto group was 5.13 and 5.97 for the Calgary group. In the Toronto group, women were reportedly more isolated than men, with a mean of 5.42 (SD = 1.97) versus 4.93 (SD = 1.81). There was no difference in the means according to the type of housing in Toronto. Similarly, there were no differences in mean scores by either the housing type or by gender for the Calgary group. By comparison, Hughes et al. (2004), using the same scale, reported a lower mean of 3.89 (SD = 1.34) in a 2002 Health and Retirement Study of adults age 65 and older, to conclude that most people in their study experienced low levels of loneliness (Hughes, Waite, Hawkley & Cacioppo, 2004).

The Lubben Social Network Scale is an instrument designed to gauge social isolation in older adults by measuring perceived social support received by family and friends. A recent report using samples from three European community-dwelling older adult populations established a clinical cut-off of 12 or less as suggestive of risk for social isolation (Lubben, et al, 2006). Two thirds of the Toronto participants scored in the range of “risk of isolation.” While there were no significant differences between men and women, there was a significant difference when the scores were compared according to housing type: 77 percent of participants living in supportive housing scored in the range indicating a risk of social isolation compared to only 23 percent of participants living in supported housing with community supports. This result is surprising given that much of the literature examining social isolation has suggested that housing with onsite staff is associated with higher levels of social support and interaction. In Calgary, 87 percent of the respondents scored in the range indicating risk for social isolation but because of small sample sizes, comparisons by housing type could not be made.



The respondents were asked to choose who helps them most from a list of family, friends, fellow tenants, or service providers. In this study, 37 percent of the formerly homeless in Toronto said that service providers helped them the most, followed by family members (32 percent) and then friends (31 percent), a fairly even distribution. Calgary paints a similar picture with 38 percent saying that family helps them the most, followed by friends (33 percent) and then service providers (28 percent).

Employment and Income

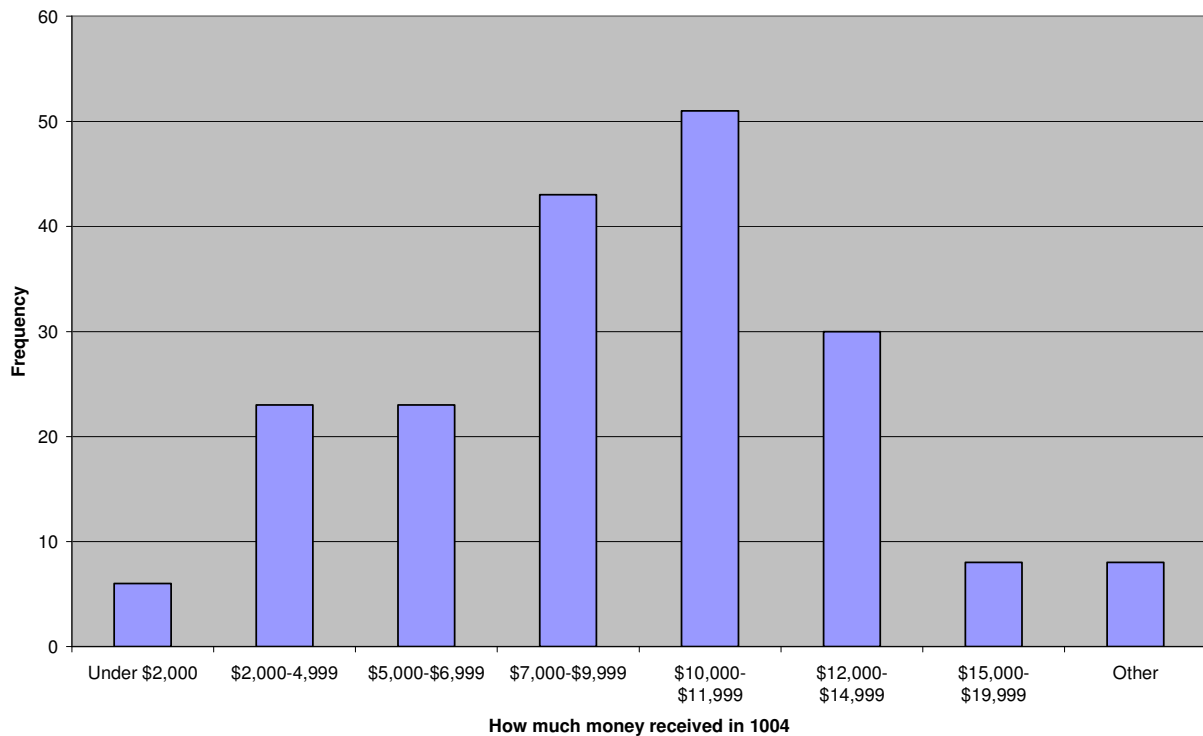
Twenty-three percent of respondents in Toronto reported employment in the past six months, with the majority reporting part-time or casual employment. However, most of the formerly homeless older adults reported being unemployed because of a disability (41 percent). Income sources reported for the last month for Toronto respondents were as follows: 35 percent of participants received Ontario Disability Support Program (ODSP), 20 percent received Ontario Works (OW), and 12 percent received wages from employment.

In Calgary, 33 percent of respondents reported employment in the past six months, with the majority reporting full-time employment, but many of the formerly homeless older adults reported being unemployed because of a disability (31 percent). Given the booming economy in Calgary this is not surprising. Income sources reported for the last month for Calgary respondents were as follows: 33 percent of participants received Assured Income for the Severely Handicapped (AISH), 14 percent received regular Canada Pension payments and 14 percent received Canada Pension Disability payments, 6 percent received Old Age Security, and 3 percent received the Alberta's Seniors Benefit.

The majority of formerly homeless older adults in Toronto reported yearly income for 2004 between \$10,000 and \$11,999, as shown in Chart 3a on the next page.



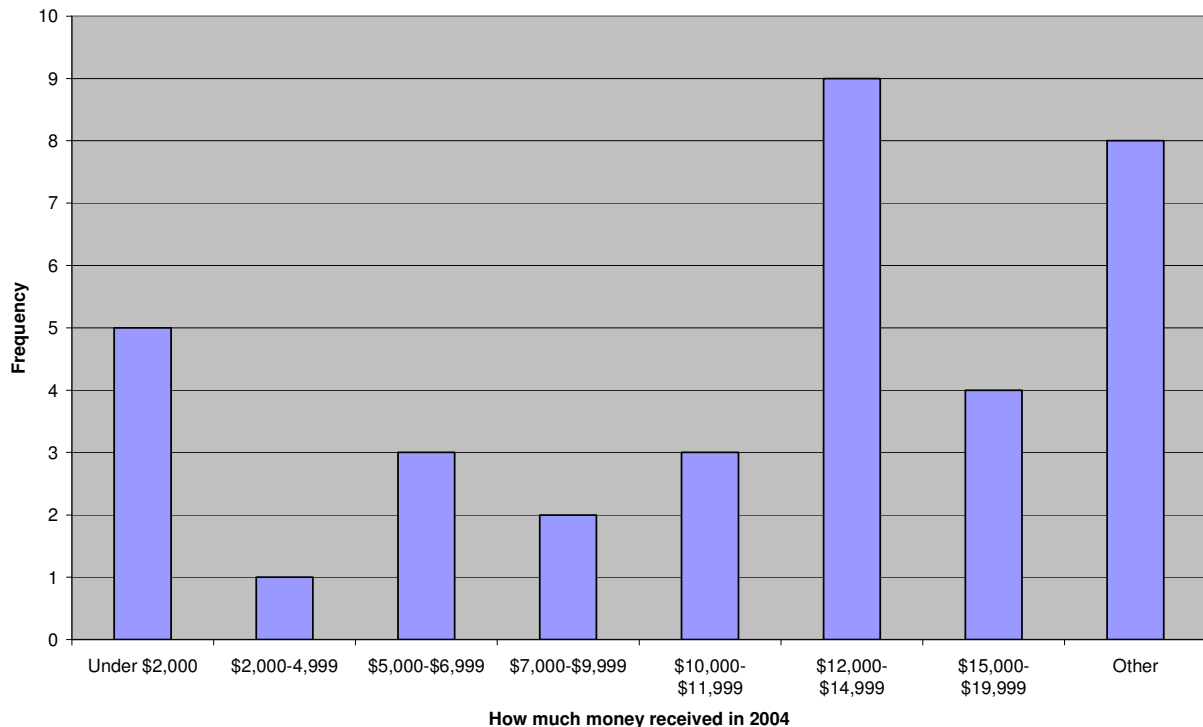
Chart 3a: Yearly Income: Formerly Homeless Older Adults - Toronto



The majority of formerly homeless older adults in Calgary reported slightly higher yearly income for 2004 between \$12,000 and \$14,999, as shown in Chart 3b. There was little variation with regard to the range of reported yearly income between men and women, suggesting that homelessness is a great leveller. The extent of poverty experienced by this group is severe: the yearly income of the overwhelming majority of formerly homeless older adults does not even come close to the Low-Income Cut-Off (LICO) rates for single persons living in Toronto and Calgary which, in 2005, was \$20,778 for both cities (National Council on Welfare, 2006).



Chart 3b: Yearly Income: Formerly Homeless Older Adults - Calgary



Lessons Learned

The samples of formerly homeless older adults in both Toronto and Calgary were not random but they did provide ideas about what works and does not work in housing older homeless adults. Several factors are very clear. Housing that is adjusted for impairments in mobility and aging is genuinely preferred by older adults. The respondents in supportive housing in Calgary were very pleased with their new facility and rated it highly compared to those in Toronto and those in independent housing in both Calgary and Toronto. Because of the very low vacancy rates in Calgary respondents in supported housing were probably forced to live in very poor circumstances which they flagged by awarding poor ratings to their physical space, privacy and cleanliness of their homes. The Toronto respondents also noted that their buildings did not meet specifications for those with impaired mobility. When the major health problems of both groups are considered – vision problems, back problems, arthritis, impaired cognition – a specially equipped environment becomes a necessary reality.



This was an issue of import to everyone in the study either noted by the presence of this type of environment or its absence.

Another clear message was about health care. The Calgary group had poorer physical health, used more hospital days and used more walk-in clinics and community health centres. Part of this difference in health status may be attributed to the fact that less of the Calgary respondents had a private physician, their care would have been more inconsistent because of the use of walk-in and community clinics and fewer had health cards. As was seen in the analyses of health service use before and after housing, emergency services, and inpatient/day patient visits decreased after housing. It would seem extremely important that every housed older adult has continuing access to the same physician.

The idea that people can be moved quickly into housing is present in the data from Calgary. The last episode of homelessness was much shorter for the Calgary group indicating that a quick housing intervention is possible. The benefits accruing to this would be substantial in removing people from the emergency shelter merry-go-round, preventing the entrenchment of homelessness and lessening the reach of the negative side effects of homelessness that haunted the formerly homeless for long periods of time after being housed. Another interesting finding that pertains to this demographic group is the fact that when full time employment was available, the homeless were likely to take advantage of this opportunity as was the case in Calgary. With more prospects for employment people have larger incomes and more opportunities to create pensions. The employment issue was vital to the newly housed homeless indicating that programs to facilitate employment would be welcomed.

Key Findings

- Of the participants who responded to the survey in Toronto and Calgary, the majority were male, which accurately reflects the proportion of men to women in the homeless population. The average age was 57 in both samples, an age both groups considered to



be “old”. Most of the participants were born in Canada and identified as ‘white,’ although Toronto had a larger percentage of immigrants and Calgary had a higher percentage of Aboriginal peoples. Most were unattached in terms of marital status and were mainly single or divorced, and over half in both samples had attended or completed high school.

- Over 60 percent of the participants in Toronto and 56 percent of the formerly homeless participants in Calgary had been homeless more than once, with men reporting significantly more homeless episodes than women in both cities.
- In Toronto, 71 percent lived in supportive housing compared to 42 percent in Calgary and the remainder lived in independent housing with the help of community supports.
- In Toronto, about 50 percent had been housed for over five years compared to only eight percent for Calgary.
- The last episode of homelessness in Calgary was much shorter than for Toronto suggesting a quicker turn around in interventions that provided support and housing.
- About one-half of the participants in both cities had found their housing with help from a professional service worker. The other half relied on word of mouth and the informal system indicating that this informal system is an important mechanism for communication.
- In Toronto, almost two-thirds of participants shared accommodation. Most found their housing “somewhat” or “very” affordable. The majority felt their housing was adequate with regard to physical space, privacy and cleanliness, but one-third reported “fair” or “poor” air quality and noise. The participants were also generally satisfied with support from the staff in their buildings.
- In Calgary, 86 percent of the formerly homeless shared rooms and mainly lived in supportive housing. Those living in supported housing were more likely to report the air quality, cleanliness, physical space and the privacy of their home as fair or poor compared to those living in supportive housing.
- Overall the health and well-being of formerly homeless older adults improved relative to health indicators for homeless older adults in previous research but were lower than



similar indicators reported for the general population. The Calgary sample reported poorer physical health than the Toronto group but better mental health.

- The top reported health problems of the formerly homeless older adults in Toronto were vision problems (63 percent), teeth or gum problems (45 percent), back problems (44 percent), arthritis /rheumatism (46 percent), depression (37 percent), nerves or anxiety (37 percent), and blood pressure (34 percent). In Calgary the problems were similar: vision problems (58 percent), teeth or gum problems (55 percent), back problems (47 percent), arthritis /rheumatism (44 percent), depression (39 percent), nerves or anxiety (28 percent), and blood pressure (25 percent).
- Both groups experienced memory problems according to the Orientation-Memory Concentration Test, (32 percent in Toronto and 50 percent of respondents in Calgary).
- In 6 months prior to the survey, two-thirds of Toronto participants reported receiving care from a private doctor, while slightly less than 50 percent saw a private doctor in Calgary. The percentage of emergency visits was almost identical for both groups but Calgarians were more likely to be hospitalized (33 percent vs. 23 percent). A larger proportion of Calgary respondents used walk-in clinics and community health centres (CHC).
- Participants in independent housing used more medical services at hospitals, walk-in clinics and doctor's offices, and made significantly more use of medical services at drop-in centres.
- In an analysis of health care utilization data from consenting respondents in Toronto, scores representing changes in the mean number of days of health utilization from pre-housing to post-housing were examined. The findings indicated that there was no significant change from pre-test to post-test for fee-for-service, but there was a significant decrease in the mean days of emergency room use, and the mean days used for in-patient/day patient care.
- The analyses of the global ratings of life satisfaction for those in Toronto and Calgary revealed that at least half of formerly homeless participants reported satisfaction, a proportion lower than ratings reported in the general population.



- The scores on the measures of social isolation and networks for both the Toronto and Calgary respondents indicated that formerly homeless participants were at considerable risk of social isolation and relied heavily on service providers for support. While the Calgary group strongly relied on former spouses, the Toronto group spread their social networks out more evenly across siblings, children and extended family members.
- Only one quarter of the Toronto participants reported any income from employment in the previous six months. Most participants reported income from the Ontario Disability Support Program (ODSP), followed by Ontario Works, with a smaller group accessing other disability benefits and old age pensions. In Calgary, 33 percent of participants received Assured Income for the Severely Handicapped (AISH), 14 percent received regular Canada Pension payments and 14 percent received Canada Pension Disability payments.
- The majority of participants reported a yearly income for 2004 in the range of \$10,000 to \$11,999, well below the current Low Income Cut-Off. Notably, a high proportion of participants relied on food banks and meal programs.

Qualitative Analysis

Semi-structured interviews were conducted with 35 formerly homeless older adults in Toronto and 18 in Calgary. Although there were rich descriptions of the antecedents to homelessness and experiences while homeless in the transcripts, for the purposes of this report, the analysis focuses on exits from homelessness and the events and experiences most closely aligned with the period of time when participants had secured alternative housing. The report provides a brief demographic description of the respondents who participated in the in-depth interviews followed by an analysis of the transcripts organized around three central themes and concludes with a summary of the key findings.



Socio-Demographic Profile

Table 1: Sociodemographic Profile: Qualitative Interview Group, Calgary		
	Total Percent (N) TORONTO	Total Percent (N) CALGARY
Gender		
Male	47 (16)	78 (14)
Female	53 (18)	22 (4)
Age		
Mean	56.26	58.72
Standard Deviation	5.70	5.96
Marital Status		
Single	35 (12)	6 (1)
Now married	6 (2)	6 (1)
Common law marriage	--	--
Separated	21 (7)	17 (3)
Divorced	32 (11)	67 (12)
Widowed	6 (2)	6 (1)
Born in Canada		
No	18 (6)	17 (3)
Yes	82 (28)	83 (15)
Population Group		
Aboriginal	14 (5)	17 (3)
Black	3 (1)	--
Chinese	3 (1)	--
Latin American	--	--
South Asian	3 (1)	--
East Asian	--	--
White	69 (25)	83 (15)
Other*	8 (3)	--
Education		
No schooling	--	--
Some elementary (grades 0-8)	6 (2)	11 (2)
Completed elementary (grade 8)	--	6 (1)
Some high school (grades 9-12 or 13)	29 (10)	33 (6)
Completed high school (grade 12 or 13)	17.5 (6)	22 (4)
Some trade, technical, college, business school	12 (4)	6 (1)
Completed diploma/certificate	17.5 (6)	--
Some university	--	11 (2)
Completed university degree	9 (3)	6 (1)
Masters or doctorate	6 (2)	6 (1)
Other	3 (1)	6 (1)
Housing Type		
Supportive housing	79 (27)	78 (14)
Independent housing with community supports	21 (7)	22 (4)



The demographic profile found in Table 1 shows that the Toronto respondents who agreed to be interviewed were almost evenly divided between males and females with slightly more females. The average age of the group was 56 years, most were unattached, either being single, separated or divorced and the majority were born in Canada. The majority also classified themselves as white with Aboriginals being the next most identified group.

Almost half indicated that they had completed, or had some high school education. Most were living in supportive housing. The Calgary group was somewhat different since the respondents were more likely to be male, they were two years older, more were divorced and, overall, had a slightly higher education. Like Toronto, the majority lived in supportive housing.

The Voices of the Formerly Homeless

The section below presents the voices of formerly homeless older adults according to three main themes that were identified in the transcripts: the persistent effect of having been homeless even when one is housed; the significance of social inclusion to the extent that a house feels like a home and one is a member of the community and the larger society, and transitions and barriers to transitions that are concomitant to being housed. The themes all overlap and bear witness to the complexity of the lives of the previously homeless. Here we separate out each theme and their permutations so as not to lose their import.

1. Residual Effects of Homeless Experience

The lingering trauma of homelessness

Participants conveyed that exits from homelessness were neither discrete nor final. “Homeless effects” reported by participants were so profound that several participants described themselves as still “homeless” even though housed. Frequently, housing supports were characterized as insensitive to the demands of transitioning **from** homeless to housed, leaving participants feeling vulnerable. Security, safety, and trust were key areas that



participants felt were lost or damaged and needed to be slowly reestablished: *“You lose your dignity, your trust.”* (Toronto participant)

For some the effects of homelessness were so vivid that they were characterized in similar terms to the symptoms of post traumatic stress disorder:

“I can’t go back into that area where I was. Because I went there twice now to see my psychiatrist. And both times I left there just – ‘I can’t go back here, I can’t.’ It was the shelter – that’s where the doctor is. So once a month on a Tuesday, I’d go down there and I’d go into a sweat.” (Toronto participant)

“You see you can’t make peace with all these demons, you can’t. They will always be there. The only thing is, is you’ve got to be able to handle it. Like when there are some days, like I’m able to talk about it now, but some days I can’t, you know, I can’t. My throat just [...] you know and I can’t talk about it some days so that means leave it aside and just ignore it okay, throw it aside it’s after all it happened in your life and it’s something you can’t forget you know, no matter what, how old you’re going to be you’re still going to remember that no matter what kind of therapy you go through or whatever, it’s still, still you will remember that for the rest of your life. So you’ve just got to focus and learn that part of it that it will be there no matter what you do. It will always once in a while, it will always come back you know. You’ve just got to be able to handle it.”
(Calgary participant)

Frequently, participants invoked the language of recovery to describe the process of healing from the stress induced by the conditions of homelessness.

“Because the transience of the shelter system it takes its toll on your mental, physical, emotional, financial, and spiritual well-being and it’s something that takes you so long to recover from that I think unless you go through it you don’t understand. When I was finally housed I sat up every night, I didn’t sleep for about 4 days. I sat up every



night I was afraid to close my eyes and go to sleep because I had been so accustomed to catnapping in the shelter system.” (Toronto participant)

For other participants the impact was less catastrophic but nevertheless required a long process of rebuilding and recovery:

“And it took so long to rebuild. People didn’t understand it. It took so long. Like it when you’re down, even one year of homelessness. It takes at least three years to build back. I’m not kidding. It takes at least three years to cover that one year.” (Toronto participant)

“I think it’s very difficult for them because they have forgotten what it’s like to live with a roof over their head. They’ve forgotten that there’s people that care about them. And they’re trying to get them to care about themselves and they’re feeling so down and out that they’ve just have forgotten how to feel, how they feel about themselves.” (Calgary participant)

The need to understand

Participants frequently complained that “homeless effects” were not adequately understood by service providers. One participant described how important it was for housing workers to appreciate the challenge of the transition from the streets to housing by respecting the wishes of newly housed tenants. Participants spoke of the need for behaviour to be understood in terms of recovering from the trauma of homelessness and not to be ‘pathologized’.

“I told staff downstairs – don’t bother me for a couple of weeks. I just want to sit in my apartment. I want to watch the TV anytime I want to watch instead of being told when to watch it. I’m going to cook whatever I have in there. And they go, ‘okay, we’ll leave you alone.’ And I did for a week, I sat here. I went for walks. I came back and I’m like – just such a feeling of relief.” (Toronto participant)



“It depends on the staff. A lot of the staff are nice but some of them they just don’t, they just, they just think they’re scum or something. They handle you like you’re scum, period and more or less you shouldn’t be here, some of them you know. And it’s not, I don’t think it’s right but you just ignore it and just don’t talk to them as much, as less as possible and just don’t even pay it you know just, just let them be that’s all just ignore them you know.”
(Calgary participant)

2. Being “at home” in Housing, the Community and Society

Participants from many different contexts emphasized that being housed is not the same as being at home. Participants struggled with being at home in their housing, their community and in the broader society.

Being at home in housing

About half of the participants reported assistance in finding their housing by professional workers, while the other half relied on their own resources, including informal networks of information and directly accessing housing lists.

“A worker came and found me on the street and put me in the shelter system and she’s an outreach worker on the street. She helped me to navigate the welfare system. And this person advocated on my behalf as one of her cases for me to get supportive housing and that’s how I got supportive housing.” (Toronto participant)

“I thought I had lost it. I think if it wasn’t for that social worker that I met... like I was used to handling my own problems whatever they were but I really would have lost it then if it wasn’t for her. She stepped in and, you know, got me housing and everything else.”
(Calgary participant)



“They should have a worker that’s strictly interested and deals with the older people. And the worker should be getting, the older people into like supportive housing. They should be somewhere else, they should be, not be in a shelter.” (Toronto participant)

A number of systemic barriers were identified including a profound lack of affordable, age-appropriate housing; insufficient access to housing workers; lack of individualized assessment and placement; intolerable conditions that push people out of the system and out of reach; lack of supports for the diversity of needs (e.g. mental health, different abilities and ageing); inaccessible or inadequate income supports; and inequitable priority status and discrimination. These systemic barriers often intersected with personal vulnerabilities to create formidable challenges to find housing.

“Well there’s places out there that’s 30% of your income so that’s about \$250 to \$300 but ...that’s one thing that I may be able to look at down the road somewhere but right now not.” (Calgary participant)

“But it was just, also despair because everywhere you go, it doesn’t matter...government housing, non-profit private housing, the list is so long. You think you’ll never get it.” (Toronto participant)

“The only thing is, is like, I could get this \$26.00 a week, but they expect you to look for housing, but they wouldn’t give you any transportation, no tickets or nothing.” (Toronto participant)

“Goodness of Fit” and Security Once Housed

Two key themes emerged in participants’ descriptions of being at home in their housing: “goodness of fit” and security. Goodness of fit, that is, the degree to which the housing community (the “community” of other tenants and staff at the housing site) and the conditions of the housing reflect the needs and preferences of participants, was relevant to both the physical and psycho-social dimensions of housing. The theme of security was linked



to both security of tenure and security of person. Both dimensions were associated with the quality of support available and whether that support enhanced feelings of security or hindered it.

Security of person

Participants valued housing that was located close to services and supports. Easy access was especially important given the challenges of transportation, especially if mobility was diminished due to aging and illness.

“It’s near practically everything I do is downtown, so it’s, it’s near things that I do. So that’s really important and especially if you don’t drive or have a car, or whatever.” (Toronto participant)

“But I needed, you know, a clean place to live that was affordable. And you gotta remember too I know these people down here so for me to go and get a room at let’s say up in... way up in there, I wouldn’t know anybody, you know, and I wouldn’t be within walking distance of places that peak my interest. There’s a library, you know, they’re all down here.” (Calgary participant)

Safety was a key consideration in determining the merits of a housing location. Many participants reported feeling unsafe in their housing and in their communities: *“But then it’s not only, the people in this building. It’s out there – where – the shooting is going on, the stabbing ...”* (Toronto participant)

However, as one participant noted, safe neighbourhoods often were prohibitively expensive for persons receiving income assistance: *“It’s a very nice area, but it’s a very expensive area. There’s nothing, here for people that are on fixed income. I like this area, because it’s safe and it’s clean. So that, that makes up for the rest.”* (Toronto participant)



The contrast between safety and supports was described as a trade-off between stressful and threatening environments and the benefits of service-enriched neighbourhoods:

“It’s a very difficult neighborhood. Four weeks ago we had a shooting incident right outside my building, right, you know, a drug, apparently a drug war. But there’s all kinds of other social recreational community places within the neighborhood.”

(Toronto participant)

Threats to security of person were commonly expressed as fears of violence and victimization by the criminal actions of other tenants and other persons in the community.

“My experience is, by and large, pretty nasty. Well, I’ve seen many people die. A guy threatened me with a knife.” (Toronto participant)

“There are people that are living here that abuse substances. And there are other people in the neighborhood that come in and they know when cheque day is and they come in and sell drugs to people and stay with them and get them to party their money away.” (Toronto participant)

Some participants found refuge from threats inside their own units but then reported feeling captive in their own apartments: *“Inside of the apartment I am all right, but I am thoroughly isolated. That is actually working in my mind. I don’t feel comfortable at all. Because it is something like being locked-up in a unit. That is very discouraging, and that causes me lot of distress in my mind.”* (Toronto participant)

Another area where safety and “goodness of fit” emerged as key themes was in participants’ descriptions of shared versus self-contained housing units. The majority of participants expressed a preference for self-contained units, citing the freedom and independence afforded by this form of housing arrangement.



“I’m getting more used to it as the days go by...ah, because...I am getting more independent again...like, as I live here I know I can come and go as I please, that’s the main thing on the order...that’s the main thing that’s really important, that I can come and go as I please...ah, I have up to three months to disappear and give my room up, so I’m saying, it’s not that my rooms not going to be there, it’s going to be always there.”

(Calgary participant)

“I like the individual thing is because if you live with somebody else then there’s rules: when do you have to be in, and, and when you get up so you’re not as free.”

(Toronto participant)

“Okay, and it’s clean and new, alright, and everybody has their own room and bathroom I think, that’s a very big deal, okay, having your own bathroom. When you’re homeless not having your own bathroom is a tough thing and when you share all the time because you’re either carrying everything you’ve got in a bag, you know.” (Calgary participant)

Privacy, of person and of belongings, was felt by many participants to be limited by shared arrangements. Feelings of insecurity associated with multi-tenant units were linked to “invasions” of privacy and property.

“Kind of an invasion of privacy. I mean, in my opinion as long as I’m not disturbing anybody, by making a lot of noise, or, or partying, or something, I should be able to invite a friend back for a coffee.” (Toronto participant)

“We have a communal fridge...my food has gone missing on a few occasions. Like milk and things like that, like silly little things but I mean they still cost me money...”

(Toronto participant)

Forced shared accommodation with incompatible persons was seen as a source of considerable distress by many participants.



“The places that they could find accommodation are shared, and this is something that a lot of them don’t want to do. They don’t want to share the bathroom, share accommodations. At X where there’s shared accommodations – the women there are miserable because they have to share their living accommodations with a lot of people who have mental disorders” (Toronto participant)

However, several participants valued the safety and proximity associated with shared arrangements: *“But the point is it’s too dangerous because if a person is living by yourself it’s more dangerous and my place got broken in I don’t know how many times.”* (Toronto participant)

Also, a number of participants commented on the assistance and social connections afforded by shared environments.

“And having three people around, well there’s good times, there’s bad times, but to have my own bachelor apartment. I’d sit there. I’d go nuts.” (Toronto participant)

“The man next to me is very good, he helps me out a lot you know because I can’t see too well and if I lose something he helps me find it.” (Toronto participant)

Security of Tenure

Many participants spoke of the need for greater supports for the day to day demands of maintaining housing, especially money management. For many participants trusteeships were an important support and quite a few participants expressed frustration at the lack of affordable trusteeships available.

One participant vividly described the consequences of insufficient money management supports describing the return to homelessness as totally “unnecessary” and highlighting the crucial intervention that could have ensured secure tenure:



“They need someone there to actually pay the rent for them. I found that one woman who wasn’t, didn’t have the good mental state, she wouldn’t pay the rent and they would leave a notice on her door and then after 3 of these notices she’s evicted. And she’s homeless underneath the building, and she once lived in the building, and there was no need for that. Had she had someone ensure that the rent would be paid or had they taken the rent out of her cheque, or had they had pre-authorized payment, this was totally unnecessary for her.” (Toronto participant)

“Goodness of fit”: “Like” Community or Diversity?

Preferences expressed in regard to the characteristics of other tenants were another area where “goodness of fit” captured the diversity of perspectives and the importance of client determination. Often participants spoke of security when describing their perspectives on whether a “like community” of tenants was viewed as a negative or positive characteristic of their housing.

Participants expressed varied viewpoints on living with others who had common challenges: gender, age range, ethno-cultural identity, and/or socio-economic status. Commonalities were often seen as creating shared experience and community. Alternately, housing segregated by a common demographic or ability was seen as creating “ghettos” of disadvantage.

Clustering tenants according to similar health challenges was seen as comforting by one participant: *“I like living here because I’m not under pressure and they know that I take medication and they know I’m drowsy in the morning so they put up with it. That’s what I like we all take medication here so that’s one good thing I’m not criticized with them saying, ‘you look so tired what’s the matter with you,’ they know I’m on pills.” (Toronto participant)*

Other participants felt that special needs clustering was undesirable, even dangerous:



“I wanted to be away from sicker people.” (Toronto participant)

“I just feel that I’m living in a really vulnerable situation and I think that I would rather be in a mixed population as opposed to a population where most of the people like myself have mental health challenges. Because one of the things I’m seeing is that the neighborhood is a vulnerable neighborhood and it’s kind of like people know that, and it allows you to be vulnerable and targeted.” (Toronto participant)

“We’re getting all kinds of different personalities, people that have literally just come off the street, that don’t have any cleanliness and they seem to be walking around with long beards and dirty clothes and smelling. And they just have no um they just get away with it. So when they go out of the building it makes the building look bad when you go out of the building and you’re dressed up fairly nice. They go out of the building and they look like they’re still living on the street.” (Calgary participant)

Active use of substances in the housing site and in the community was seen as negative by most participants whether they were current or former users.

“The main one that comes to mind is you can’t drink or use drugs in the house. Which is good for me. I don’t drink or use drugs right now and I wouldn’t want it in the house cause it would be a trigger for me.” (Toronto participant)

“And it’s quite a challenge, you know, for someone who’s lived on the street as an addict and a homeless person – cause I have to keep going through all those streets in my journeys today.” (Toronto participant)

Most former users valued a “dry” house policy. However, a few participants felt that there should be a distinction between use and abuse. The distinction was often expressed in terms of whether it violated other tenants’ rights to peace and security: *“There’s a handful of people there that I’d made good friends with that are – they smoke pot, and then they have a*



little drink of something...but that's about it...they won't do any of those drugs...which is good, I'm trying to put behind me all the people that abuse.” (Toronto participant)

Although in certain circumstances gender-specific housing was viewed as necessary, such as with survivors of abuse, most participants preferred a mixed gender housing environment. Participants were split on whether age-segregated housing would have a positive impact fostering connection or a negative impact creating an environment of inactivity leading to “*waiting around reading death notices.*” (Toronto participant)

“Cause he's seventy...and, and got nothing left...but give him the senior housing where he can associate with people his own age, and he'll start to rise above.”
(Toronto participant)

“Ah, some of them that are in here are not....would be better off in a secure care, or ah, um, a situation whereby there would be more care on a 24 hour basis.” (Calgary participant)

“I don't want to be in a place with all seniors. And the reason is because some people, some people get older than other people, you get say five people and they're all sixty and three people have not led an active life. So, you don't know whether they'd be a conflict because I've never lived in a place where you just have seniors, or sort of one age span.” (Toronto participant)

“I don't know I never I don't know any because there's not much for them old people to do like in this building they play bingo. I think they learn to dance and that's in the city. I don't really know what they do because I don't have nothing to do with them.” (Calgary participant)

A few participants mentioned a preference for housing that was sensitive to ethno-cultural membership, mentioning the benefits of shared culture in mediating conflict:



“The same community people will be better because if it is in our culture we have to agree with cultural ways, but if it is in different community there will not be cultural agreements. So that can cause conflict later.” (Toronto participant)

Most participants felt that diversity of tenure, with mixed subsidized and market rent units, was critical to building healthy and secure housing communities. However, one participant residing in such a housing setting spoke of discriminatory targeting of the behaviours of tenants in subsidized units:

“Because people living with them [market rent tenants] in rent-geared-to-income housing, they don’t, they’re not the ones who are investigated. And there’s an instance where it wasn’t right, and I even told them that this person was coming and helping me. So they had a worker come in and do an inspection and say oh, you have somebody living with you and report me and put me through that whole thing. It was an abuse of power, and it was an abuse of confidentiality.” (Toronto participant)

Security And Staff: Support Or Surveillance?

The actions of housing workers were associated with both security of tenure and of person. Most participants characterized the association as positive: staff enhanced safety through presence and intervention. Others framed staff actions as “surveillance” that left the participants feeling targeted and unsafe.

Many participants felt that onsite staff were critical to preventing, monitoring, and acting to diffuse threatening events. However, these participants expressed dissatisfaction with the dwindling resources devoted to onsite security measures and with the limited power of tenants to take on this responsibility.

“When I first moved here, they had staff here every day, almost seven days a week. Because X opened up they’re getting all kinds of people and crackheads and all this. We’ve had guys coming here with a German Sheppard, that goes through the place.”



But now you're lucky if you see these people three times a week. Cause the, the place is self-run now." (Toronto participant)

Participants highlighted establishing "trust" and relationship building as critical components to the quality of support provided by on site staff.

"I have experienced some good ones, and some not so good ones. It's just like everywhere else when you get a good one you're helped a lot. Because then you can, you can really trust them, and open up and say, okay, I have a problem." (Toronto participant)

Knowledge brokering or education about programs and services was another important function that staff played in the lives of many participants, including helping them to find their current housing.

"It was the social worker. These people will help anybody to get into a situation like this...ah, a lot of people don't now this places exists...I never heard of it until I was in hospital, but ah, it's ah, it's, it's, I know a lot more now than I knew before I went into hospital. Before I didn't know this place existed, I had no idea about how to get in here" (Calgary participant)

Many participants also spoke of the importance of having information about the programs and services available to them.

"So what I'm saying is I think there's a terrific crying need to make residents, particularly, I know you focused on my age group but to make residents generally and specific for my age group, to make them more aware of what's out there you know I just think there has to be there has to be more of an awareness and I guess if you want to put a crass term to it those services have to be more they have to be better marketed to residents you know because the bottom line is it's pretty easy to become a bum over there and live



there forever and never work any more or live within the system. When there are all kinds of avenues to get out of this, to get out of that kind of an environment that stereotypical shelter environment and get back into mainstream society.” (Calgary participant)

Although many participants spoke of the value of onsite staff, one participant spoke of the limits of housing-linked support and the need to seek assistance outside of the housing setting: *“And I know one of the things they say is, well, we can’t be everywhere at once, and that is true, but basically supportive housing doesn’t always mean that you are getting support. In a lot of cases it’s just that they’re doing maintenance and making sure that you’re paying your rent and maybe not breaking civil law rules. But in terms of supportive housing you really need outside support systems.” (Toronto participant)*

A large number of participants commented on the inadequate staffing of support workers and expressed sympathy and respect for their overwhelming workload. One participant, while recognizing the multiple and sometimes excessive demands on service providers, stressed that immediate attention is critical and without it desperation can easily set in: *“You talk about professional people, they’ve got too many caseloads, they have too little time, if they have an hour, you’d be in heaven already, you’d be so happy. A lot of things are very urgent. You need to get it now but, but they can’t help you now. And...you’re left wringing your hands. You get depressed and everything like, I’m left alone again! Like shucks! How could it be, like I’m stuck in the cold again.” (Toronto participant)*

A significant function of onsite staff valued by participants was early intervention to ensure security of tenure, and security and well-being of person. The two were paired by several participants with rental arrears being a signifier of other problems. One participant described the process as being vigilant to the “red flags” that might indicate the need for stepped-up support:

“One of the biggest red flags that one should note as a housing worker, other than the obvious, is somebody didn’t pay their rent on time. That doesn’t always mean that the



person just doesn't want to pay their rent. Maybe something's going on with that person...there should be some kind of an investigation like a phone tree or an email or something that's available. To let people know that this person hasn't been seen and hasn't been going around the normal things of life and I guess the mail and the rent are the two red flags.” (Toronto participant)

Although many participants spoke positively of staff support stressing the “security” and ease of access afforded by onsite staff, some participants felt that staff were “intrusive” and diminished their sense of security.

“My ideal...pretty much what I have. But possibly with more options as far as visitors and as you know, being able to, to come and go without being under a magnifying glass.” (Toronto participant)

The contrast between support that fosters autonomy and self-direction and supports that are based on “rules” is captured in participants’ experiences around housing policy addressing substance use. Differing perspectives on harm reduction is a good example: some participants reported that their housing settings had zero tolerance policies, while others described a framework that adopted the parameters of universal tenant rights and responsibilities and facilitated self-regulation by the housing community.

“I smoke pot in my apartment and a lot of people there do. But I smoke it medicinally. They're pretty good about that. When I first moved in there, I told them I smoke medicinal marijuana – is that going to be a problem? They said ‘no, not really, but go and talk to your neighbours.’ So I did. I went and talked to both neighbours on both sides of me and one of them smokes, the other one didn't... and they said: ‘No, we don't care, go ahead.’ When you're behind your door you do you what you want.” (Toronto participant)



Housing as a site for community development: Tenant participation and engagement

For many participants feeling at home and secure was enhanced by participation and decision-making in the housing community. Participation ranged from having input into the selection of new tenants in shared living arrangements to engaging in tenant councils or committees. Decision-making power ranged from determining social recreational programming to tenant-led forums that were the first intervention to resolve tenant conflict or rental arrears.

“I’ve been on the resolution board. I love going to the meetings. I love going on building tours. And love, there are some people who get along very well in here. Very well. And I love the staff. Because I have a rapport with them, and if you’re not doing something the way they think it should it be done, they’ll tell you up front.” (Toronto participant)

“First we have the Tenant Resolution Meeting. Anybody that’s involved in any crap that comes down, and we have a forum. And we say our piece to him. And then we try to resolve it before it goes to the Tribunal. And if it doesn’t get resolved there, and his partner agency talks to him, and that doesn’t work, then he’s off to the Tribunal.” (Toronto participant)

However, several participants commented on the uneven consideration and implementation of tenant input:

“I was told by the staff that somebody didn’t want me in that particular unit now, but when I made my feelings clear as to who moves into our unit I was ignored so I don’t know, and you know, I get these different rules for different people and, as far as I’m concerned, that’s nothing because you should have one rule for everybody or nobody.” (Toronto participant)



Being at home in the community

One way that participants were able to feel that they were valued members of the community was through their engagement in informal networks of support. Another way was through “giving back” through volunteering in the community. Being at home in the community was described by participants both as a process of giving back and getting connected to formal and informal networks, as well as to family and friends. Many participants reported establishing new avenues for social connections but a substantial number reported still feeling disconnected and isolated.

“Getting connected”

Housing was seen by some participants as a source of social capital. Just knowing a few tenants could engender feelings of security and belonging.

“I don’t want it too big, because then you don’t get to know anybody. That’s too much. And the safety factor. You’ve got to know at least two or three people, in the building.” (Toronto participant)

“I found four or five of the women in my building were very, very supportive. I mean from everything from, coming to the door with meals, when I came home from the hospital...asking – did you eat today, and bringing me a meal...or going shopping or asking me if I needed anything...or you know offering to help with things like shopping or laundry or whatnot, so it was uh, it was really, really enlightening really, to how it kind of brings people together.” (Toronto participant)

The support of family, when available, was often characterized as instrumental to health and housing stability:

“Emotionally, you know, he’s [participant’s son] there for me, we watch a movie, we eat a pizza together, we do this, we do that. He cooks for me, comes over a couple of days, cooks something, we eat together and I just find that I’m healthier in doing that.”



I have stated this to my family doctor, the family doctor has written letters to ensure that I am able to keep the two bedroom apartment so that my son can give me the support, it's necessary for my health to have that support in place.” (Toronto participant)

“Almost every one whom I can honestly call family is family and has major concerns about my future, okay, about where I'm going and the condition I'm in. They would all most definitely drop whatever they're doing to come out and help or to take care of me if I needed it.”
(Calgary participant)

Other participants found “family” in their housing setting or among other communities: *“I'm in the perfect place and environment cause everybody else is running around crazy so you get into team work family thing and it's like working with a bunch of functional family members I've been adopted by.”* (Toronto participant)

Some participants felt that social connections were best supported in an age-segregated housing environment but a few felt that diversity of all kinds, including age range, enhanced social interactions.

“You got to be in a place where there's older people. Because if you don't fraternize with older people, how are you going to know. You know, if you're with 25-30 year old people. What do you talk about?” (Toronto participant)

“I interact with people of all ages, because one of the things that I've noticed with that is that by interacting with babies, toddlers, teenagers, people in their twenties, people my age and older, and especially people older than me. I think it gives me more of a well-rounded focus in my life.” (Toronto participant)

Social programs that are empowering and reflected tenant interests were suggested by many participants as key to health and well-being:



“Small groups meeting or small support groups meetings, making them creative and giving suitable advice to them, so they can empower them more and more. For example, teach them or give training, and it is a strength for them. Alzheimer disease, so many other diseases are developing, so if they are occupied by creative ideas continuously that is good for their health, and they get inner strength when they think they also contribute to the society.” (Toronto participant)

Some participants were still quite connected with people from the homeless community and continued to feel at home in service settings they frequented while homeless:

“It’s open seven days a week. They take care of homeless people, and people who live in shelters it’s just any you know – it’s just amazing. I spend a lot of time there playing billiards.” (Toronto participant)

“Oh yeah, like when summer gets around I will be going down to the park, I will be spending nights down at the park with friends and the kids...you know like I’ll take a sleeping bag and everything and just kick back for the odd night here and there, fishing....you know, the night vision is good...so that’s what I’ll be doing in the summer time.” (Calgary participant)

Several participants reported that they received all or most of their support from professional service providers.

“Well, professional support is the only other support I have. I’ve turned my back on everybody else.” (Toronto participant)

“I want to see my GP [general practitioner] a lot. I see him this Friday, I like him very much, I’m going to tell him, listen, my mother died I have more time on my hands can I see you more often?” (Toronto participant)



“Staying disconnected”

Many participants expressed a lingering sense of isolation; some, in fact, felt more “connected” to the homeless community than to their current communities.

“Just friends, general acquaintances that I’ve met from the hostel. Not very many cause I don’t get close to people I don’t like them getting close to me.” (Toronto participant)

“I live a very lonely life because I don’t have any friends. People have wanted to be my friend here in X. But it’s [people] that I’ve met in the shelters that are now living in their apartment but I don’t want to hang on to any part of that life.” (Toronto participant)

“Um hum yeah I’m lonely... I think I’m one of the loneliest guys here and the longer I stay in my apartment the lonelier I get and the madder I get and the more I want to go out there and join them (the homeless).” (Calgary participant)

Poor mental health was cited as both fueling isolation and as a potential outcome of continued loneliness and disconnection. Aging was also identified by many participants as exacerbating isolation.

“And you being depressed, you have a big enough problem with isolating yourself, like I can do that easily enough.” (Toronto participant)

“And the younger ones in the building, well they go out, and do this and that but myself, I think I’m the oldest one here in the building, but there’s several within my age group that don’t go out anywhere. They just wander around, go back to their room, watch TV upstairs.” (Toronto participant)



“I miss being with other people. I’m alone all the time. I’m in a single room up there, nobody knows where I am of significance in my life and in fact those people are dwindling.” (Calgary participant)

A lack of identity with other older adults also contributed to self-imposed isolation on the part of some participants:

“Well you know and not that I’m involved in any because I’m not you know. I’m pretty busy with my work and but you know I’m aware of a lot of the senior activities, the traditional senior activities because my parents were involved in a lot of them. You know I like to think I’m 55; I’m probably still too young to get involved in those things because a lot of it is a state of mind.” (Calgary participant)

Almost all participants recognized the value of social networks but spoke of the many barriers to achieving such supports. One participant captured the paradox of needing help but being too ill to seek help:

“Well sometimes I can get so, so, depressed that I can’t even, like if I see it coming I can sometimes reach out for help cause I’ve learned how to do that. Sometimes when we’re on the brink of the edge we’ll go to ask for help but there’s only so much we can do because the whole cycle of a downward curve of depression is not one of logic and sanity. It’s the exact reverse. And when I can catch it then I’ve learned now more readily to ask for help. Even though I know even asking for help can sometimes be an insurmountable.” (Toronto participant)

Another barrier to asking for support, expressed by several female participants, was the difficulty in transitioning from caregiver to care receiver: *“And I’m supposed to be looking after everybody else, so, I, I can’t bear to think that they have to look after me.”* (Toronto participant)



Reluctance to seek help was also attributed to pride in self-sufficiency, but as one participant commented, that may gradually give way to the awareness that seeking support is a reasonable and sensible option: *“It gets to the point sometimes, you want to get...Don’t be stupid. Swallow your pride. What the heck you know. Because that’s what they’re there for – to help.”* (Toronto participant)

Many participants explained that they did not want to “impose” or “burden” their families and friends and therefore they avoided asking for help.

“Family – absolutely not. They’re going through their own individual traumas and they’re not a source of comfort or support.” (Toronto participant)

“My friends are all married. And they got their own problems.” (Toronto participant)

Other participants reported that they had attempted to reconnect with family but were rebuffed: *“I’ve asked him so many times I could turn blue but he [brother] doesn’t want me, he doesn’t want me to get involved with the children too much, I don’t know why he’s different that way. He wanted my mother to come up, he didn’t want me to come up.”* (Toronto participant)

“I’d say some of them are really pretty old and uh, pretty shakey...and this is the last resort because their families don’t want them, they even say that, you know, at the table...because when they’ve got no use for yah they throw you to the dogs.” (Calgary participant)

Some participants were resigned, even determined, to remain disconnected from their families and described longstanding estrangement.

“Now, my mother, still has a relationship with my sister, she lives in X, she babysits her kids sometimes. She’s never, ever tried to contact me...in my whole life...I don’t



call her my mother, I had nothing to do with her. She had nothing to do with me, I'd nothing to do with her." (Toronto participant)

"I don't get along with anybody in my family. I just keep them at arms length."
(Toronto participant)

"No, I've been estranged from my family for about 25 years. No, I don't want to have anything to do with them." (Calgary participant)

Persistent feelings of shame that fueled self-imposed exile from friends and family were reported by some participants.

"Nobody can find me here. I had a session with my doctor a couple of weeks ago, and that day he said: 'What would make you happy today?' And I had a close friend, I said: 'It would make me happy if I could talk to X.' And he said: 'Why don't you?' And I said: 'Well I couldn't possibly let her know what's my life.' He said: 'I think you should try and phone her.' So I did one day. I bought a phone card, and I phoned. And she couldn't believe it was me. I mean we both just cried, and cried and I said: 'X it's so terrible – I've lost everything' and she said: 'Well I knew that honey.'"
(Toronto participant)

"I can't even meet anybody, cause I can't tell anybody about my life... nobody can know who I am, or where I live. I can't do it. I can't at all." (Toronto participant)

While some participants felt that their experience of homelessness had significantly eroded their capacity to make social connections, others had a long history of social isolation, which was somewhat ameliorated by congregate living:

"All my life I tried to make friends and I always ended up lousy we'd split and that's it, so I don't know, but here I like it here, I don't want to move from here." (Toronto participant)



“Well, I don’t know, I just prefer to be by myself. I’m not a social animal.” (Calgary participant)

“Giving back”

Most participants reported volunteering as a meaningful way to connect with members of their community, as well as a way of “giving back” to the community.

“And whatever extras that I get or that I donate – I always hand them out to the guys here, and the girls here, too. So I like to be helpful, like that because at the shelter they helped me out. So I want to give back.” (Toronto participant)

“So, one day I went back to them and I said: ‘I’d like to give something back to you people, I said, ‘I don’t have any money, but I got lots of time. Lots of time.’ So they asked me if I wanted to volunteer in the food bank. So I did. I volunteered there for a couple of years. And to the point where I was driving the truck going to the food bank doing the pick-ups and then I started not long after that volunteering at the drop-in centre.” (Toronto participant)

For some participants “giving back” was less formal but still meaningful part of their lives: *“Here, I’m kind of the social director some days.”* (Toronto participant)

One participant characterized the “giving back” as a way for others to benefit from the hard lessons they had learnt through their experience of living without housing:

“I advocated for that person because I thought, well maybe a third party situation would allow this person to get help. One of the things I noticed is that, or I learned from myself, is that when somebody advocates for you, you get better help, you get better attention, and people treat you with more respect, they’re more civil, polite, attentive, and forthcoming with the kind of care that you get.” (Toronto participant)



Another participant highlighted the value of peer volunteers who were able to share common experiences of homelessness and were able to empathize with the challenges of aging or health related issues:

“I do breakfast every day. I interact with these guys and we are at the age group where a lot of us are dying but that’s just the age group, there are a lot of deaths. These people need some kind of moral support, social support, someone to talk to. A lot of them just die from depression cause their family is gone and they are on their own, and they are very old and they need a purpose.” (Toronto participant)

Although participants reported many incidences where the experience of homelessness continued to negatively impact their well-being, a number of participants describe how reflecting and sharing those experiences with others had transformed them into a source of learning and information.

“I’ve been in a lot of bad situations and negative situations and a lot with my friends who are addicted and I’ll kind of relate what happened to me and how I coped with it or how I didn’t cope with it. And I hope in some way they, they can get some kind of meaning from it.” (Toronto participant)

Informal networks and resources were mentioned as critical supports by many participants. “Street” knowledge was characterized as invaluable and often more accessible and responsive to shifts and opportunities than professionalized systems. Participants expressed being both beneficiaries and producers of this knowledge and many felt that these informal resources should be supported and funded to expand access to this valuable source of information. For example, peer-designed pamphlets and peer outreach programs to the homeless community were mentioned as ways to ramp up “word of mouth.”



“I will I say, ‘You know what, I’ll find out from housing staff.’ Or I’ll phone XXX, or I’ll give them XXX phone number. Phone them. They can direct you to the right direction. You always, you should always, if somebody gets something to you, you should always, be willing to pass it on to anybody who needs it. Not just to keep it for yourself.” (Toronto participant)

Being at home in the community was also spoken of terms of establishing formal partnerships with community-based agencies. Participants felt that these community partnerships provided an opportunity for enhanced support not formally linked to housing and offered the benefit of portability and flexibility:

“Everybody that’s here – has a partner that put them here. So, when any problems that she [housing staff] can’t resolve – she’ll phone up the partner and say come in and talk to your client.” (Toronto participant)

Community-based supports were especially important to those living in independent housing that were frequently characterized as opportunities to connect with persons from a “like” community: *“People are less able to accept the services and people are less able to provide services to different communities. But help is necessary. Help is a must. If they come out and talk openly that could be great. Our people are coming here and sharing and talking – this is the big achievement.” (Toronto participant)*

Being at home in society

Social Exclusion: Discrimination, stigma and mainstreaming

Ageism was a form of discrimination cited by many participants and experienced in the areas of work, housing and social activities.

“They want to work but there’s no jobs over 50 because number one is that they discriminate, they’d rather have people now younger generation. So where are the jobs for older people? I’m hearing this all the time.” (Toronto participant)



“I’m 9 years older and I think I wouldn’t be able to get in, I think they discriminate in that regard and if she had her choice again she wouldn’t let me move in.” (Toronto participant)

“Well...being socially accepted, you know, I think it’s a drawback in being older, you know, you’re not invited out as much, I’m never invited out really, you know, so I think that’s a factor.” (Toronto participant)

One participant reflected on the marginalization of older adults, tying exclusion to labour market participation and spending as evident in the targeting of only certain age groups by various media: *“They’ve worked all their lives really hard and now they’re kind of kicked out, who cares about old people if they don’t have money if they’re not contributing? Advertising, marketing is all geared to 20, 30 year [old] married people.”* (Toronto participant)

As a counter to ageism, participants felt that being valued for their age and experiences was a critical component of feeling at home in society. A number of participants highlighted the differences among older adults focusing on their competency and lived experience as potentially valuable resources.

“Offer social activities: what I think would be good if you could get them involved with younger people and share some of the wisdom, knowledge so that they don’t end up broke, alone, you know. Some of them are just too confused and helpless and they just need a lot of supervision. But, some of them are very sharp and they have their sense of humour and they really like people and have some wonderful stories and could share what they know. Things you don’t read in history books like the guy telling me about bootlegging in the 20’s, he was there.” (Toronto participant)

Utilizing the skills and knowledge of older adults was not just valuable to the recipients but was a source of pride to those participants given the opportunity to contribute:



“I feel satisfaction, gratification. I feel good about still being able to do something. And I really like the appreciation that I get from some people for doing so.” (Toronto participant)

Many participants commented on the “gap,” which was characterized as a special class of ageism limiting options available to persons 50 to 65 years of age. Participants referred to this gap in terms of being “too old to be young and too young to be considered old” or being “invisible.” Lack of employment opportunities, appropriate housing, and services for this age group were mentioned as areas where this gap was evident.

“It is not only hard to find work, it is also hard to find services that involve you and housing. It’s almost like from 30 to 60 you’re not helped, you know like younger groups, older groups or you have to be abused to get help and then you get almost immediate help. Basically we’re stuck in a rut you know, you can’t go where the young people are but you can’t go where the seniors are either because you’re not considered a senior.” (Toronto participant)

“Yeah basically I’m trying to get into ... like I say into subsidized housing and that frustrates me a little bit when you’re told that you have to be 60 and I’m 58 and I’m in a position to ... that I feel I should be able to get in, that frustrates me a bit.” (Calgary participant)

However, as one participant pointed out, programs and services for this age group have to be sensitive to the unique needs and desires of the group and not be the same program with a different name: *“sometimes they treat the older people as still the younger people, and the service is not that much difference except that, your qualifications differs: because the program is only for 50 years and older. Maybe they get funding for it. But to tell you the truth, they didn’t treat us any different.”* (Toronto participant)



Discrimination based on socio-economic status was frequently mentioned by participants, labels such as: “hard to house,” “welfare bums,” and other forms of “poor bashing” had significant impact on their identity and self-esteem.

“I didn’t want them to know how sick I was, or how bad I felt, and I think because I was broke, I didn’t, I felt I had no worth. That’s, that’s really true, I really felt worthless.” (Toronto participant)

Interestingly, one participant commented on the levels of stigma attached to different income support programs noting that general welfare is associated with greater stigma than the disability benefits available from the Ontario Disability Support Program (ODSP):

“Before I was on, before I went on ODSP, I was on welfare which I was more ashamed of than ODSP. Because again, at least if you’re on ODSP you’re showing that you’re not capable of working but on welfare you just look like a lazy bum. So I’m actually almost proud that isn’t the right word but I feel more, I feel that I’m not as embarrassed to be on ODSP as opposed to welfare.” (Toronto participant)

Receipt of social assistance was repeatedly reported as limiting access to decent housing.

“These places were really rat traps, you know, and a lot of them that were going to accept people who were on social assistance. Many landlords were not talking to anybody on social assistance or they will accept social assistance clientele but just don’t look after the places at all. They’ll take the money but they don’t pay anybody to maintain the buildings.” (Toronto participant)

“What made it difficult was when you went to these apartments and they asked your income and you told them you were on social assistance and they just kind of say ‘oh’ you know? Cause I think in the long run, they didn’t have the experience of people on



social assistance and they can't say that they won't give you housing because of that but that was the impression I got.” (Toronto participant)

Participants felt that entrenched assumptions about welfare recipients limited the employment supports available: *“Because I don't agree with the stereotype that people that live on welfare, live on social assistance just don't want to work. I think they do, they just don't have job skills. A lot of them have addiction issues and they just have been out of the job force for so long.” (Toronto participant)*

Some participants still felt the stigma of having been homeless, others expressed how once housed the stigma was translated to “hard-to-house” or to negative assumptions regarding tenants of social housing.

“Like one circle is what you call ‘High Society.’ And the other circle is all these homeless people ... but the thing is even in the homeless circle there are people who are very, very intelligent, very articulate but other people don't know. You know. Outside of the homeless community, some people didn't understand it, didn't see it. And they just lump everybody and say: These are all stupid people, they're all bums, they're, they're nothing that's it.” (Toronto participant)

“I was embarrassed to tell anybody where I was living. I'm still embarrassed to tell people that I'm living in subsidized housing because to myself I fell into the stereotype of the drug addict that couldn't find housing.” (Toronto participant)

“Being treated like a piece of property. A piece of furniture. A non-person. A ‘hard to house.’ A social outcast.” (Toronto participant)

“They make me a little ashamed and they depress me.” (Calgary participant)



Mainstreaming was mentioned by several participants as a strategy to enhance social inclusion and reduce stigma and discrimination. Participants referred to “normalizing” as a positive goal, although one participant felt that “normal” was intimidating.

“If we could come out we’d get a lot of services and we’d meet other people like ourselves who are looking just to be normal just to be normalized in terms of day by day activity, day by day living, not feeling alone or isolated.” (Toronto participant)

One frequently mentioned link to the mainstream was that participants were living evidence that persons who are homeless are as diverse a group as those who are housed and that there is no specific type of person who is most at risk of homelessness.

“You know, you see how fragile you really are - everybody is. Two pay checks away from living on the street.” (Toronto participant)

“I’ll walk into a bank and I’ll get professional advice. And they used to intimidate me before because, I wasn’t working, or I wasn’t making the money or whatever. You know what, they tell me: ‘You know I’ve been in your same situation. I’ve been in a position where I’ve had five dollars in a bank.’” (Toronto participant)

3. Transitions

The third major thematic cluster was that of transitions. Participants did not feel that they were “settled” or “retired”. They expressed a desire to move forward in a number of areas including transitioning toward home, toward health, wellness, and greater social inclusion, and toward greater economic security.

Many participants expressed frustration with the barriers they encountered as they moved toward achieving these transitions. One participant characterized a number of these blocks as “feeling stuck”, “feeling out of touch”, “feeling too young to be old” and yet still wanting to secure a job and more appropriate housing.



“At this particular time I’m at a stalemate. I don’t have a job. I don’t have any prospects for a job and I don’t have a prospect for a change in my living arrangements yet. But I don’t intend to leave it at that you know, I’m too stubborn a person to just let this go on forever. I still want a place of my own and in order to do that I’m still going to have to find a job. I don’t know what job. I don’t know what my capabilities are anymore, everything is computerized. I would have to take a computer course, which I will look after when I’m finished this cooking and health course. One step at a time, basically I take every hour and the next hour and the next hour I’m not looking that far ahead. I figure pretty soon I will be a senior and then what the hell am I going to do. I don’t want to be senior I’m too young to be senior.”
(Toronto participant)

Transitioning from housing to home

Many participants made the distinction between finding a home and living in temporary housing that provided little more than a “fixed address.” For many participants, their current living arrangements were perceived to be transitional until they were able to secure something better, something closer to their ideal of “home.”

“Because it’s not a homey atmosphere. I’m living with seven strangers half the time, when the unit is full. You have no privacy, it’s like living in a dorm. Except, people here are meaner.” (Toronto participant)

“I still think right now it’s temporary for me. It’s for medical reasons that I’ve been placed here and I volunteered to stay here. I don’t have anybody to take care of me, look after me. I’ve got a few medical problems for which I’m supposed to be fed on time and, you know, and being living alone I haven’t been taking care of myself good enough. That’s why to start with I’ve been sent here and there’s nobody who would like to take a sick man into the house and look after him on a full-time basis.” (Calgary participant)



“Ummm....myself, ah, this is not an ideal situation but for a temporary basis, yes, it is good. For my ideal situation would be on my own again.” (Calgary participant)

One participant went as far as characterizing his current living arrangements as “still homeless” emphasizing the significant difference between having housing or having a home: *“But no, I still feel homeless. I really, really would like to get a little bachelor somewhere self-contained place. I, I don’t like living with a lot – I’m too old for that.”* (Toronto participant)

Several participants expressed some concern over losing their current supports in the event of moving and were hoping for continued access: *“But that, that’s what I would do, when I leave is say: ‘could I come and access the staff if I ever needed to know something.’”* (Toronto participant)

Many participants reported a desire to transition toward greater independence associated with self-contained units.

“My ideal place would, would be a little senior’s apartment some place. My ideal housing would be to just have a place on my own. I’m almost 65, maybe I’ll be able to afford it then.” (Toronto participant)

“My ideal: I would have my own apartment. That way I could have my grandson visit me, spend the night. I could have my family over for dinner. I could have friends stay the night without being worried that they’re going to be ratted on for staying the night. That’s about it; my own independence really in that way.” (Toronto participant)

However, participants expressed frustration over the barriers to accessing other housing options, whether through internal transfers or externally through another housing provider. The most frequently cited barrier was the limited availability of affordable housing.



“I know a few older adults who are looking for housing right now, and they’re having a hard time finding it because, ah...well, housing is pretty hard to get into, but you ah, ha ha, can’t help them. What I find challenging is, to have to go through the system. Forgive me for saying this, a lot of them don’t have the patience I have, so...there are a lot of people, everybody, it is a bit of a different situation, different set of problems for different people, and I think the biggest thing to find is, down payments...like a lot of seniors that are in that situation don’t have all that cash, like it costs pretty close to a \$1,000 over \$1,000, \$2,000 a month to move into an apartment. I can’t save \$2,000 a month, that’s a lot of money, if they’re like me and they don’t save their money when they have no income, they just don’t have \$2,000 bucks to come out.” (Calgary participant)

“I’ve explored possibilities and I always came back to this house. I was on that waiting list for years and they kept on writing to me and saying, ‘look do you want to renew your application’ and I said ‘yes,’ and then finally, I said forget it and I asked them to withdraw my name because they didn’t find anything.” (Toronto participant)

“The rent is a big issue and welfare only pays \$325.00, you don’t get any place for \$325.00. I have looked for subsidized. I’ve applied, I have to go to a few. But they’re very far and they are very hard to get into.” (Toronto participant)

“You try to transfer – Oh my God! It’s so hard to transfer once you get into it – you’re stuck....And you, you kick yourself many, many times and say, why did I do that? But at, at the time when you apply – I tell you, you will do everything or do anything, yes, you’re just so desperate – you don’t care.” (Toronto participant)

“The problem is that there aren’t enough people helping in transition. I get the impression that they expect me to be here for the rest of my days.” (Toronto participant)



“What I believe is that for anybody, okay, other than with medical problems or emotional problems or something say somebody 50 years old there should be something in the system subsidized housing if they’re not in a position with a job they can afford any more. But if they are working there should be some kind of subsidized rent for at least at 50, at least because if you’re in a position where you’re trying to come out of it you can’t get a job for \$10, \$12 an hour and walk in and pay \$700 rent, you know that yourself.” (Calgary participant)

Other participants were happy to remain in their current housing, but felt that some improvements were necessary.

“I’m quite comfortable where I am. I’ll probably be there until they put me in an old age home. I will, you know, because I’m very comfortable with my apartment, I have a lot of space and no one intrudes on our life or our lifestyle or anything.” (Toronto participant)

Participants expressed aversion to long term care facilities: *“And I could never for the life of me see myself going to that kind of place. I don’t feel that I’m ready for that, you know, because I can interact with people of all ages and I don’t want to be tied in to older age groups.” (Toronto participant)*

Transitioning toward health, well-being and social inclusion

Health and Wellness

Although health and well-being varied across participants, most participants acknowledged alternative housing as a critical first step toward improved wellness and quality of life: *“I can touch my foot on one side of the wall and pretty well stretch to the other side. But it’s, it’s all I really need, for the time being. This is another stepping stone for me. I’m working my way back out of here, so I’m working my way back up the ladder again. And this place has been very, very good for me.” (Toronto participant)*



Most participants reported that their health, including their mental health, had improved since securing housing.

“And when I came here my health improved. And my mental health improved. I just take the pills at night and I’m fine. Another thing is my pills come here and they’ll take them in the office for me, and they’ll give me my pills to me.” (Toronto participant)

“My health is getting a lot better. I did have high blood pressure when I came in here, too. And they finally got it back to where it’s normal now.” (Toronto participant)

“A nurse at X said, you should review your medication with your doctor, because I don’t think – at this point now that your housed, you don’t need all that. So I did, I reviewed my medication and I went to the psychiatrist and I told him, and they reduced it to – I was 8 pills a night, they reduced it two.” (Toronto participant)

Some participants identified access to better nutrition through housing meal programs as vital to improved health: *“I’ve gained weight and everything here. I was very, very skinny and I [was] anemic when I came here. I’m not now.”* Others felt that immediate staff intervention was key to maintaining health: *“My hip went out while I was in the bathtub and I couldn’t move. So I had to crawl out of the bathtub and literally crawl along the floor. So I phoned staff.”* (Toronto participant)

However, a significant number of participants reported still struggling with health issues but that they were slowly making gains and were able to access the support they needed.

“Now that I’m housed, it’s better. I’m trying to climb out – back up, and the progress is climbed, maybe one, two, steps up, and then slippery one floor down. And I keep going up, and then I keep going down. I see the light but I’m not there And it is also a



bit despairing although, although it's a different kind of despairing now.” (Toronto participant)

“I think I still need a lot of support. I’m working really hard to get out of this terrible depression and – it’s just – I take a lot of happy pills now. But when I recognized a couple of years ago that I was getting in a bad place, every time I would hit bottom I’d think – oh my God, I can’t believe this is happening to me. But I found out that, that wasn’t even the bottom, that I hid another cellar underneath that recently. So, I wouldn’t trust myself, to just be out on my own right now.” (Toronto participant)

Participants reported placing their health needs as a central priority and learning how to advocate to ensure their needs were met: *“Now I’m, I’m big on my own health. When I got the kidney stones, a couple of weeks ago I went down, and I told her that I’m not doing anything until these stones are gone. Well she goes, ‘well that’s okay.’ Well, I said: ‘I know it’s okay; I’m not asking your permission, I’m telling you.’ I’ve got to think of myself.” (Toronto participant)*

One participant identified the need to learn, value and have autonomy over self-care as crucial to achieving gains in health and wellness: *“It has to originate with me first that I am entrusted and they see I have no idea of how to go about this, how to take better care of myself, because I’ve never done that – I’ve never cared.” (Toronto participant)*

Several participants connected securing housing to having a greater sense of agency over their lives and well-being.

“I feel that I’m in better control than I have been for a long, long, time like I’m on the upswing. That’s the nature of living with bi-polar. Sometimes you’re just in a hopeless state and sometimes you’re like 2000 miles ahead of yourself, or 2000 miles behind yourself, it’s learning how to live with self limitations and strength.” (Toronto participant)



Home is the one environment where most people anticipate a high level of control and, as one participant stressed, having control is of great significance for a person who has experienced the chaos of homelessness. A number of participants felt that their current housing arrangements did not afford them any real sense of autonomy and that supports were intrusive and invasive.

“Your life was very regulated cause you always have to answer to your own personal worker on a monthly basis. They come in to your apartment to check out how the apartment was being maintained to see if it was up to par, up to standards, and I always felt that, you know, I didn’t have any freedom.” (Toronto participant)

Another limitation to achieving greater autonomy mentioned by a number of participants was that of inaccessible fee-per-service supports. Several participants commented that the every day supports critical to remaining housed and healthy were often only available to those with greater incomes.

“It’s an organization that works with the elderly and they might cook their lunch, or vacuum or do their laundry, do their medication, help them with their medication. They do cost money and people in here that don’t have the money, unfortunately some of them really do need help but they don’t have it.” (Toronto participant)

Some participants, though valuing their independence, described it as something that had to be re-learned or revived after experiences in environments where control was either imposed, as in the case of shelter living, or largely absent, while living in the streets.

“Institution wise, you’re pretty well programmed. But when you go into housing, you’re different....You have to do things for yourself, and do things for others. And you have to adjust.” (Toronto participant)



Many participants expressed that having a routine was critical to regaining their sense of well-being and that routines operated as a mechanism to maintain a sense of control and autonomy: *“One of the things I’m noticing really late in the game is that for the person who lives with mental health issues the most important thing that really works is routine. Like, and sometimes we get off of routine and when we lose our routine everything falls apart.”* (Toronto participant)

Health Care

Although many participants reported better access to health care providers, some described feelings of not being adequately cared for, often characterized as not being listened to: *“A lot of us don’t get along with our doctors or can’t communicate with our health care professionals.”* (Toronto participant)

Several participants spoke of not being able to afford appropriate care: *“I’ve never been to a psychiatrist that’s really, in my books, ever been any good. And I think a psychologist might but I can’t afford a psychologist cause that isn’t paid by OHIP. And I’m at present trying to find somebody that works on a sliding scale that will see me that’s good. Because I do have a lot of unresolved issues and I know that. So I would like to get help with those. It might help me carry on with my life.”* (Toronto participant)

Several participants commented on the assistance provided by housing staff in accessing health care: *“If anybody in here needs medical attention, the staff has no problem. Now, any medical help that you need. Let’s just say, you’re broke or whatever, or if it’s necessary. They had no problem taking you to the hospital, the doctor, and go with you.”*

Transportation issues were frequently reported as preventing some participants from accessing the services and supports they needed: *“But they don’t have any support for people to get around. Let’s say you have a doctors appointment in Scarborough, I have no way of getting there other than public transportation. For me to take public transportation number*



one I have to have the money for the ticket, or if it's really hard for me to get around there is no way of me getting help to get from here to my doctor.” (Toronto participant)

“There’s the self-help downtown but I haven’t used those services for quite some time now because of the difficulty in transportation there and the time that they’re offered.”
(Calgary participant)

Not only was mobility presented as a formidable challenge but participants noted that it was exacerbated by supports and services which failed to accommodate differences in mobility.

“So, sometimes you get frustrated. We don’t have the mobility, sometimes the thing is your limbs are not working. So well...it takes a lot longer, you know to get there, but people didn’t understand it. They don’t allow us the travel time and say: ‘What do you? What are doing? The whole day – what are you doing?’ We are moving! We are getting there!” (Toronto participant)

Another challenge mentioned by several participants was finding services and supports that were relevant to their experience. For one participant, the difficulty was that programs were not age-segregated and were a poor fit for older adults: *“I went to meetings and found that the older set didn’t participate or if they did, they sat in the back. I’m not going back there, no more, I got no association with them...they’re young, they don’t know what it’s all about, you know.” (Toronto participant)*

Another participant commented that even programs which are supposed to be targeted to older adults were not providing age appropriate service: *“they really didn’t understand what the older people need. My hearing is not as good anymore but they didn’t realize that and sometimes we don’t do things as fast as when you were younger, sometimes we don’t remember as good as before. So, they, sometimes, they don’t have the patience, you know.*



And, sometimes they treat the older people as younger people, and the service is not that much difference.” (Toronto participant)

For a few participants deteriorating cognitive capacity was beginning to limit their capacity to get help: *“Because in my younger years...I used to know where to go, when I needed help. I’m 71 and I believe that when you reach 70, when you so start to lose your memory and, you get a mixed up, cloudy and you can’t remember yesterday.” (Toronto participant)*

Social Inclusion

Feelings of being excluded and invisible were not limited to service provision but were diffuse and crossed multiple contexts. At the furthest end of the continuum of concern was a fear of social exclusion so profound that it was described as a process of “disappearing”: *“Being invisible, being left out, being forgotten.” (Toronto participants)*

Such expressions of hopelessness were often attributed to years of disappointments: *“Right now I don’t know where I am, or where I’m going. And I actually don’t look any further than today. I’ve been too disappointed too often when I have made any kind of plans or, or thoughts that this is what I’m going to do. I just don’t believe in it anymore.” (Toronto participant)*

Many participants feared being alone. A good proportion expressed that deteriorating health was a significant source of concern not because of diminished capacity itself, but because it would lead to greater dependency and isolation.

“Dying alone. I’ve been married twice. I’m in my 50s now and I’m not looking for another relationship really. ’Cause I don’t think I’m strong enough to handle someone else’s problems. I’m solving mine, so I’m not sure I have the strength to do that but at the same time I do worry about, you know, living on my own in my



government subsidized room and dying there one day and nobody will know until I smell.” (Toronto participant)

Transitioning along but not off the poverty continuum

The majority of participants reported that access to housing subsidies, either through social housing providers or through rent supplements, was vital to preventing returns to homelessness. Housing subsidies were critical to moving participants along the poverty continuum.

“Comparing this type of housing to my market value apartments I’ve had in the past, how can I put it, well-being in this housing it’s just a bigger help – it keeps me on the straight and narrow. It keeps me away from homelessness.” (Toronto participant)

“I feel very lucky to be in the situation I’m in now because I could never find a place that is equivalent to what I have. I have my own room with a lock on it. I can store my own food, I have use of a telephone, laundry facilities, I could never find that for the amount of rent I’m paying.” (Toronto participant)

Even though most participants had access to housing subsidies and income support they spoke of the struggle to “make ends meet.” A clear indication that participants had not moved off the poverty continuum was that even the basic necessities were often described as “beyond reach.” Several participants made the connection between income inadequacy, impossible budgeting, and the risk of becoming homeless.

“The government is not giving them hardly any money to survive on and everything is going up. So they’re only on fixed income, so how’re you going to survive? Either pay your rent or pay your prescriptions. Either one or no food. And so there’s more and more people going to be homeless.” (Toronto participant)



Some participants linked income inadequacy to feelings of lack of control and to being at the “mercy of the system”: *“I feel the government’s in control of my life. Because they pretty much dictate where and what I’m going to do, when I’m going to live...and definitely what my income is going to be.”* (Toronto participant)

Income inadequacy was not only linked to housing instability, many participants spoke of the impact to health, particularly through the mechanism of poor nutrition and dietary choices. Many participants reported being forced to choose between paying the rent or eating a decent meal: *“They tell you to eat properly: eat more vegetables, eat more...fruit. Well, who can afford the so called ‘proper’ things.”* (Toronto participant)

“I never have enough money to buy groceries or to have a diet that would not have the earmarks of poverty. Like diabetes, heart conditions, all those various things that we go through because of our diet.” (Toronto participant)

Participants felt that meal programs available onsite were vital to securing adequate food: *“I just scrape by, I don’t go to restaurants and I don’t go to McDonalds much anymore, I’ll go to Coffee Time maybe and have a bagel and coffee and hope that the meals here will suffice. So that’s why I depend on the X house, you know.”* (Toronto participant)

“I was too sick to cook. So it’s a good thing I have a dining room here.” (Toronto participant)

One participant mentioned that the cost of a public transit token often made it impossible to go to a meal program: *“And it still takes tokens. People here, don’t have any money, so even when they have the meals over there it still costs us a token, which is a big thing.”* (Toronto participant)



The high usage of community-based meal and food programs reported by participants is a vivid testimony of persistent poverty: *“It’s inadequate for my needs. For all needs. It’s survival but I definitely need the help of food banks to survive.”* (Toronto participant)

Continued use of these supports was described by several participants as evidence of the valuable resources and knowledge acquired during their homeless experiences.

“I go around the city and...I eat my meals for free. I go to the Out of the Cold program. So I travel all over the city. I’m busy all day doing that. I’m really thank, thankful for that...I found and learned about through homelessness.” (Toronto participant)

“There’s not enough money, and so you must find food. One thing good about it is since you were in the shelter system, you know where some of the drop-ins are, so – you go there, and get a food, but the only problem with them, you have limited time. When I just got housing, I still did not have enough money, so I still was walking to a lot of places.. so my day was just – keep walking from one drop-in, to have lunch, and start walking to another place for dinner and start walking to someplace else for something else.” (Toronto participant)

“The last two weeks of any month I’m going to the shelter for meals.” (Calgary participant)

Continued reliance on food banks and meal programs engendered a sense of continued dependency that impacted participants’ self-esteem: *“I don’t want to line up for meals ever again. I don’t want to have to sign in or sign out of something...I’m tired of just being one of the numbers.”* (Toronto participant)

One program mentioned by several participants that provides an opportunity for inexpensive meals, social interaction, and avoids the stigma and feelings of dependency that



accompany free meal programs was that of community kitchens with membership fees: “We belong to the community kitchen which is a really nice innovation that they’ve developed as a meeting place. The community kitchen is all the people involved each contribute \$20.00 a month toward purchasing the raw goods and each of us submits a recipe and then they subsidize the cost.” (Toronto participant)

A theme similar to that reported in participants’ comments on the shelter system, emerged in the context of descriptions of the “poverty or welfare wall.” Income support was viewed as a system that limited participants’ ability to transcend poverty. For example, participants cited limits to asset accumulation as imposing a “vicious circle” that keeps people dependent on support systems: “I would like to save some money... they won’t let you save any money. If you have any more money than five thousand dollars, they think that you’re too rich. And then they’d just stop assisting you...but the thing is they don’t see what are you saving that money for. I’m not saving that money for stupid little things. I’m saving money to get myself out of the situation. But they don’t see that. And they say well you just cannot have that kind of asset. It’s not asset it’s investment in my future.” (Toronto participant)

Participants cited several disincentives to employment built into income support programs such as losing health benefits, losing disability status, and high clawback rates that subtract a high proportion of earned income from income support monies.

“I get about 600 and change a month. But, the kicker is the medication. For what I take, I get a booster pack delivered to me for once a week, for that one week, it’s four or five hundred dollars. So that’s \$2000. If I’ve got to go to work and pay for that myself, I’m done.” (Toronto participant)

Several participants felt that the employment support programs available were insensitive to individual capacities, needs and preferences, consequently creating another barrier to achieving greater economic security: “I’m really sick of it because this program, that’s supposed to help you recover, they figure out you can’t do anything else but cook



because you're a woman! So they put you in this food program to cook. By golly I never cooked in my life." (Toronto participant)

Most of the participants reported that securing employment was a high priority but many expressed frustration with the limited options available: *"And they want to work but there's no jobs over 50 because number one is that they discriminate they'd rather have people now younger generation."* (Toronto participant)

Age discrimination was cited by many participants as a key barrier to employment: *"I've discovered that irrespective of how nice my resume looks...when they see me live. I go for the interview. It's every excuse under the book...No, they can't legally say anything but you know that they're looking at your age."* (Toronto participant)

For some participants ageism intersected with ableism and lack of appropriate skills and education: *"Now if you don't have a skill over the age of 50, there's a lot of people do have skills but people with disabilities they don't so they're left out. And they're trying their hardest but they're turned down: 'You're too old' or 'you don't have the skills' or 'you don't have the trade.'"* (Toronto participant)

However, for a number of participants even if work were available conventional employment was described as a poor fit.

"And it's really discouraging when you finally decide 'I think I'm capable of going back to work' and part of the reason I went back to work was pressure from welfare and pressure from friends and relatives. I tried and I lasted 2 weeks and I was fired because I was just making mistakes. I've got a very bad memory. I suffer from depression, I'm a recovering addict. And I just couldn't do the work." (Toronto participant)



“I tried working and I just haven’t got the stability to maintain it, you know, I think I could work in a shelter environment.” (Toronto participant)

Several participants mentioned the value of peer supports. Participants felt that engaging people with personal experience of homelessness or of poor mental health would not only enhance the supports provided but would provide the peer with a genuine opportunity for recovery: *“Why don’t you employ some of these guys having problems. They can do job, and maybe that is really recovery, a good job that they can work together as a team. Then I would say that is recovery. But the thing is every thing, is top down, top down, top down. And people, don’t have any say, don’t make any decisions.”* (Toronto participant)

Although the majority of participants expressed some concern for future financial security, one participant felt that the experience of homelessness had provided them with the skills to survive on very little and consequently a drop in income was not a source of worry: *“The way I look at it, you know, I survived in the shelter with no income. I’ve survived on 90 dollars a month, including going to food banks. So whatever happens, I’m sure I’ll survive whatever else comes up.”* (Toronto participant)

Not only were income supports characterized as inadequate they were also described as precarious. Many participants feared that they would be cut off at any moment.

“You know sometimes I’m afraid to turn the key in my mailbox, cause there could be a letter from welfare, saying, well you didn’t get a job, so.” (Toronto participant)

“They review your case. And they usually do it every 2 years but I think they can do it at anytime. And I’d be terrified if they told me that, in their opinion, they thought it was okay to start working again. Because I’m not.” (Toronto participant)

“You know, it really affects you when you’re homeless or right on the edge and I know I’ve been on the edge all my life because the edge with homelessness ... you’re



on the verge with homelessness when you don't have they say three months pay in the bank so if you lose your job, shit. I've lived pay cheque to pay cheque all my life."

(Calgary participant)

Some participants were cautiously optimistic that future pensions might improve their financial circumstances but the majority feared that pension plans would be even more inadequate than their current income supports. Generally most participants under the age of 65 feared that "retirement" would leave them with "not enough to live on." The connection between failing health and more limited access to health benefits was mentioned frequently as a source of grave concern. Whether transitioning to senior income supports was viewed as positive or negative was influenced by a participants' current income source: general welfare or disability benefits, the former providing much less than the combined OAS/GIS entitlement.

"I don't know whether it will make a lot of difference but I think when I get social security, old age pension, which is just a year and a bit away, that it might make me a little more independent, or at least help me make some different choices." (Toronto participant)

"And although you get more if you wait until 65, if you're receiving OW [Ontario Works] you're required to collect the Canada Pension so that they can reduce the OW. I don't see that at the age of 60 there will be any financial improvement by doing so, however, I'll be required to do that." (Toronto participant)

"The older you are, sometimes you need more medication and stuff like that. Health wise you're pretty well going a little bit downhill and then you're trying to get money to try to either cover it, or make it much better, or have surgery or replace hips and stuff like that. Right now, there's social assistance, so your eyeglasses are taken care of, your hearing aid may be taken care of but now after 65, you move from the social



assistance to CPP. Now those things are not covered. So, so I'm really worried about how am I going to live after 65. So, is there a future there?" (Toronto participant)

Some participants commented that government (federal, provincial, municipal) should play a stronger role in ensuring the financial well-being of all members of society, regardless of their past or present life circumstances.

"More money for housing, but also more money to the recipients of the government programs...being we are the richest province in Canada, we do not...those people are considered second class citizens." (Calgary participant)

Key Findings

- Participants reported lingering “homeless effects,” such as feelings of trauma and mistrust that impacted their psycho-social health and well-being, and many mentioned that recovery was an ongoing process. While health and well-being varied across participants, most participants acknowledged that securing housing was the critical first step toward improved health and wellness.
- Participants emphasized that housing ends “houselessness,” but much more is needed to support health, wellness and social inclusion.
- Participants are struggling to find “home” in their housing, their communities and in the broader society.
 - Recurring themes about housing were “security” of person and of tenure and “goodness of fit.” A wide variety of housing and support options were identified by participants but no single model emerged as a preference. Most participants expressed frustration with the conflict and “ghettoization” that emerge in clustered housing (e.g., housing that clusters on the basis of age,



gender, ability or health/mental health status). Self-contained living arrangements were strongly preferred over clustered or shared settings.

- Being at home in the community was linked to belonging to and being connected with formal and informal networks. Supportive and supported housing often provided vital connections but community-based programs and services were also a central component of many participants' social networks. Although many participants were socially engaged and frequently spoke of "giving back" to their communities, a significant number reported isolation and estrangement from family and friends.
- Being at home in society was often spoke of in terms of ending discrimination—ageism, classism and ableism—experienced by many participants. Meaningful participation through peer support, volunteering, employment or 'giving back' were identified as mechanisms for achieving greater social inclusion.
- Participants did not perceive themselves as "settled" or "retired" or "old." "Transitioning" emerged as a theme in many different areas: transitioning from housing to "home"; transitioning toward health, wellness and social inclusion; and transitioning out of poverty.
- Significant barriers limited participants' ability to transition, such as limited age appropriate, affordable housing and support options; persistent "homeless effects" and accelerated "aging effects"; "poverty or welfare walls" imposed by inadequate income and employment supports; and ageism, particularly the special class of ageism identified as the "gap" (the 50-65 demographic falling between general population and senior services).



Focus Groups with Service Providers and Formerly Homeless Older Adults

Service providers and formerly homeless persons in Toronto and Calgary participated in three sets of focus groups: (1) with both service providers and formerly homeless persons prior to data collection, (one in Toronto, one in Calgary) (2) with service providers from the housing and support sectors post-data collection (one in Toronto, one in Calgary) and (3) with participants post-data collection (one in Toronto, two in Calgary). The first focus groups were exploratory and asked participants to identify central issues to inform the design of the questionnaire and the interview guide. The second focus groups with the service providers tasked the groups with validating the data collected and with identifying how the data might inform service delivery models. The third focus groups with research participants focused on checking the validity of the early findings and prioritizing the findings, as well as linking the data to recommendations. Following is a summation of each of the focus groups. The recommendations and themes from both the Toronto and Calgary sites were very similar. Therefore, the following represents the findings from both sites. The section will conclude by highlighting the key findings from the three sets of focus groups.

Summary of Focus Groups # 1

The initial exploratory focus groups in Toronto and Calgary were attended by both service providers and potential participants. The goal of these initial focus groups was to identify key issues that would inform the development of the quantitative survey and the qualitative interview guide. Six service providers attended the group in Toronto: five representatives from the housing sector (from nonprofit and city managed sites), one representative the senior services sector and one representative from a drop-in site for homeless and socially marginalized persons. There were two formerly homeless older adults representing service users in attendance. The Calgary group was comprised of service providers only. Seven service providers attended the group representing home care services, mental health services, provincial housing programs, and older adult centres and housing programs.



Finding Housing

Service providers and formerly homeless participants spoke of the critical role that outreach services play in engaging homeless persons and helping them find housing. Participants spoke of the need for outreach services and materials to be sensitive to the needs and preferences of the service user.

“And checking out what their comfort level is. They may feel better with somebody with them that they know whether that’s a friend or one of the workers because they don’t know you.” (Toronto homeless services participant)

“I was going to add and to use clear language and not too many buzz words and to use clear language accessible language. If there's print materials to make it a good size so it's readable and to have refreshments.” (Toronto formerly homeless participant)

Many service providers and participants added that although lack of knowledge and access to resources was a concern, the core problem was the inadequate quantity of resources, particularly housing, available.

“I get the calls everyday from workers trying to find housing that's appropriate for them with the appropriate level of support. I just hear the frustration. How do I get them in? What do I do? What do I do? What do I do? And I think when you hear their frustration, you hear where the gap is because I really think there's a lot of amazing workers in the city who do know the resources and just cannot get access for their clients.” (Toronto housing services participant)

Early Stage Housing

Formerly homeless participants commented on the centrality of relationship building and respect: *“when people first come in it’s a huge intensive job. The number one thing is*



building trust because of bad experiences. Getting rapport. We have this doctor coming in and they have that trust with us and they say okay I'll give it a shot" (Toronto participant).

Respect and valuing people were emphasized by both service providers and formerly homeless participants. These principles were best expressed through supporting autonomy and honouring the capacity and knowledge that comes with age.

"In terms of culture I think there's a whole homeless culture. It doesn't matter what culture you're originally from, now you're part of the homeless culture and I think the housing needs to be real and appropriately responding to the needs of the homeless population and afford room for guests. The experience of not feeling valued for many of the older homeless men and women that are housed, they have a hard time always taking. They don't want you constantly giving them things. They want to be able to get things for themselves. There is a culture of dependency fostered in drop-in shelters [and] supportive housing. Don't worry about that, just come see me and I'll figure it out. Again there's this wisdom that comes with age, and you get sick of that and say, I'm not a baby, I can get this myself, I am perfectly capable and they're going through the whole aging process just like anybody else. Whether you're housed or not housed I think you've got to give people that space." (Toronto housing services participant)

One service provider recounted an interaction between a health provider and a client that exemplified the need to communicate and engage a client on their own terms:

"I had one client and the nurse was frustrated and rolled him into my office and said talk to him. 'He won't sign a release so that I can talk to the doctor' and she was going on and on talking away about him. I said, John, you just need to sign this sheet. But she had already gone through many words, but it was about relating to him the way he wanted to. He didn't want to be called Mr. anything. He just wanted to be called by his first name but had never been asked so that instantly set up a dynamic.



They're just really simple things like that that create barriers to service.” (Toronto participant)

“We’ve had a lot of people in and out of that revolving door in housing and they got in one location and did well because of onsite support but they were wary of us in the beginning. If they took off for a couple days we’d say, just let us know so we don’t worry about you. Do what you want to do. It’s their lives, it’s their choice. We’re there beside them and over the course of seven years we see people get to where they want to go. It’s a process. It’s amazing. It’s their lives.” (Toronto housing services participant)

Several service providers commented on the lack of integration between housing and supports, as well as the multiplicity of supports required to achieve housing stability. One participant described the lack of integration as creating ‘silos.’ One service provider spoke of the need for staff to be capable delivering both mental health and activities of daily living supports.

“The funding for older adults is silo-ish: you either get supportive housing dollars or geriatric dollars but there needs to be a meshing of that if you are to have the right staffing. With the mental health and addictions background you can make it work and be flexible. We end up serving the people we serve and being flexible. We will clean up your apartment and flush your toilet every two hours because you have delusions about that toilet or we will come back two hours later and see if you’ll take your meds. It’s about building the program around the resident rather than saying we’re senior supportive housing and if you don’t fit into us you can live in a hostel center.” (Toronto housing sector participant)

Supporting positive housing and health outcomes

Both service providers and formerly homeless participants agreed that mental health and addiction issues are very common among this group. Some have their addiction and/or



mental health issue under control (i.e., receiving treatment, taking medication, etc.), while others do not. Some refuse their diagnosis altogether, consequently refusing their medications. Others are not diagnosed at all, but it is clear that they have some form of mental illness.

“And with anyone we work with that came from a homeless experience, addiction plays a major role and major mental illness. I think we always find ourselves saying, is that when people think of seniors, we always think of cognitive mental health dementia, Alzheimer’s. We get very little of that. It’s more depressive disorder, schizophrenia, personality disorder and so we find that with my program everyone in it with an experience of homelessness has a major mental illness some undiagnosed and sixty five percent of those people are living with an addiction as well.” (Toronto homeless services participant)

“If someone’s been drinking for a number of years and you have older individuals drinking Listerine it’s much more serious at a certain age and the ability to take care of yourself may change. When we talk about the health component, that differs greatly for someone young whose homeless to someone middle aged or older.” (Toronto homeless services participant)

Service providers and participants expressed different interpretations of harm reduction housing.

“They could say that I don’t like places where I feel patronized, or places that they say they don’t care about my drinking, but they do. There’s inherent morals and getting that kind of feeling we can say all we want. We’re fine with harm reduction, and then say you shouldn’t be drinking, but rather say when you’re ready we will provide you with a referral to addiction support, but until then we’re gonna tuck you into the floor and make sure you don’t bang your head again, and that’s our commitment to you, and that we really aren’t being judgmental about it.” (Toronto formerly homeless participant)



Service providers spoke of the conflicts encountered in housing sites where there is a wide range of age, ability and rent support configurations. Given the mix of tenants there is the potential for conflict between those receiving services and those who are not. When those tenants suffering from a mental illness, for instance, experience an outburst related to their condition, other tenants may turn on them. Service providers suggested that mixed tenancy also contributes to the social isolation felt by older tenants who do not feel comfortable with younger tenants, or tenants who have more outward symptoms of illness than they do. Alternatively, service providers and formerly homeless participants reported that age-segregated or seniors' buildings tend to be isolating as many tenants are not mobile or social. Frequent death notices in seniors buildings also contribute to depression and feelings of isolation.

"I work in a drop-in, a lot of our older clients that are housed are more isolated because they're more discriminating, have had more life experiences, they don't have that buffer of everyone's my friend that young people have. I find them more isolated." (Toronto homeless services participant)

"The isolation is a major problem. There're many people who are physically disabled and a lot keep to themselves because no one meets their criteria and there's a percentage who are sick and not very mobile. You feel sorry for people but you can't let every death notice on the elevator or every person in pain let it get to you. It's very difficult to find someone to be a close friend with." (Toronto formerly homeless participant)

Central issues emerging from this focus group were incorporated into the design of the quantitative survey and the qualitative interview guide, such as how formerly homeless older adults transition into housing; the supports they access; what supports are working and what barriers are experienced; what helps formerly homeless older adults maintain housing and improve health and well-being, especially during early stage housing; and what is the extent



and character of health, mental health and alcohol use problems and of social isolation experienced by formerly homeless older adults.

Summary of Focus Groups # 2

The second set of focus groups were held with service providers from the housing and health services sectors. The purpose of the focus groups was to discuss the validity of the preliminary findings and to link those findings to practice models. Of the 11 service providers who attended in Toronto, six worked in the alternative housing sector; three worked in the support sector with representation from case management and occupational therapy, senior specific services and Community Care Access Centres; one worked in the health services sector; and one worked in the City of Toronto's Shelter, Support and Housing division. In Calgary, a total of 19 service providers attended the focus group. They came from a wide variety of settings: housing programs for older adults, mental health programs, older adult centres, shelter programs, and from health programs, including community health centres. Discussion and activities focussed on the central questions of how formerly homeless older persons find and maintain housing.

Finding Housing

Service providers felt that a central challenge to exiting homelessness was the lack of knowledge and access to resources, also reported by many formerly homeless older adults. One provider suggested that outreach should adopt a marketing approach:

“How to get resources and information to the people on the street is a marketing issue – the most prevalent method of dissemination is word-of-mouth: where to find a meal, a bed for the night.” (Toronto participant)

Other providers stressed the importance of highly visible and accessible mechanisms that allow for direct access to resources.



“All public payphones should have a sticker with a free number to call e.g. 211 to reach street help.” (Toronto participant)

“Resource booklets should be printed by region and distributed at shelters, drop-in centres, places providing meals.” (Toronto participant)

However, despite the endorsement of informal and direct access to resources several service providers noted the critical value of having an advocate, whether professional or family or friend.

Once resources are accessed and housing referrals are made, service providers felt that eligibility requirements (often dictated by the parameters imposed by funding envelopes) and the stigma associated with having been homeless present further challenges to acquiring appropriate housing. Again, the lack of harm reduction options for active substance users was raised as a barrier to securing housing.

Challenges to Early Stage Housing

Many of the service providers acknowledged the challenges experienced by both formerly homeless persons and support staff during early stage housing. Several practice models were suggested by service providers to address transition issues including the critical need for clarity at the onset as to what supports are available on site, and the importance of establishing links to resources for other needs. Service providers stressed that information must be user-friendly and ideally accessed without support. A comprehensive intake questionnaire was suggested that would assess the supports that tenants might require and/or desire. One housing manager who utilized such a tool commented on its utility to track change over time, noting that initially on-site supports, which offered assistance in adapting and healing, gave way to preferences for off-site programs that stressed “growth opportunities”:



“After one year the focus goes from therapeutic services to personal growth opportunities: art classes, spiritual growth, education, etc., which are accessed outside of the housing.” (Toronto participant)

Several service providers highlighted the significance of establishing tenancy or life skills, citing paying the rent and maintaining the units as the “two big issues.” Although such skills were identified as critical to preventing “returns” to homelessness, service providers expressed concern for the lack of funding and time available for skill-building. Peer support during the transition (e.g., budget coaching by veteran tenants and a city-wide life skills program) were suggested as options to the challenges of implementing onsite individualized programs.

“More options are needed to transition people from shelter to supportive housing. Funding specifically for the transition period when people need assistance learning to budget, shop for groceries, pay bills and keep their unit clean.” (Toronto participant)

“Lack of trusteeship programs to help people look after their money and pay rent is a big problem, especially for people living in rooming houses with little or no support.” (Toronto participant)

Examples of mechanisms to address the “two big issues” included:

“There must be early intervention with rental arrears to secure resources and as a ‘flag’ for other challenges and difficulties.” (Toronto participant)

“Hoarding is a huge issue and it goes on the housing record and may prevent further transfers. It should be handled as a TPA [Tenant Protection Act] issue rather than something imposed by management.” (Toronto participant)



Service providers stressed the significance of building trust and acknowledged that the process of adapting, trusting and feeling secure in their new living situation takes time and that homelessness is a very traumatic experience that does not immediately end once housing is secured. Providers felt it was important to acknowledge formerly homeless older adults may be reluctant to become involved with or accept assistance from service providers as a result of previous negative experiences with the service delivery system. Key to supporting tenants during this time is ensuring that self-determination, control and independence are respected. Supports must be in place but use and timing has to be determined by the individual.

Service providers felt conflicted about the issue of continuity of supports. While there was recognition of the value of supports being provided by the support person or agency that had the longest and most positive relationship with the individual, there was also concern that this often was not the preference of the new tenant.

“ Some residents say that they don’t want to still deal with the shelter: ‘I am not homeless now and I don’t want to deal with them any more.’ ” (Toronto participant)

“Once moved from shelter to supportive housing, most people don’t want any connection to the shelter system, yet most supports and services may be back at the shelter leaving them with the feeling that they are being dragged back instead of moving forward.” (Toronto participant)

All service providers emphasized that the key to mediating this issue and other challenges during the early stage of housing was developing practices that were client-centred, flexible, holistic and embedded within a range of support opportunities.

Several service providers used phrases such as “community building” or “community development” to describe the most effective practices for creating healthy living environments whether tenants were in shared or self-contained units. Critical to fostering such environments



is empowering tenants to make decisions and providing mechanisms for tenant-based conflict resolution.

“Make tenant responsibilities clear without infringing on personal rights. Community building is key. Tenant community must be self-regulating. Rules and guidelines are determined by each unit.” (Toronto participant)

“Acceptance and tolerance are key: including tenants in decision-making process when new residents come into a shared unit – not just an organizational decision.”
(Toronto participant)

Associated with the issue of community-building and acceptance was the debate regarding whether tenants prefer to be housed with persons who may have similar health and economic challenges. Some service providers felt that community development is enhanced by shared experience and “matching,” while others felt that grouping individuals with similar challenges may hinder healing and recovery.

“‘Like’ versus ‘not-like’ community: what is most desirable is an individual story, but it goes both ways – it can be normalizing to be in a mixed community, but understanding, support, acceptance may be higher in ‘like’ community.” (Toronto participant)

Many service providers said that harm reduction housing was critical, noting that there is very little in the way of harm-reduction housing, especially for women.

“Harm-reduction programs are critical not only in supportive housing but they are needed in nursing homes.” (Toronto participant)

Although harm reduction frameworks are gaining popularity in use, there is skepticism expressed on the part of many service providers and policy makers as to the efficacy of this approach.



Although there was consensus that many persons actively using substances were excluded from some housing sites, there were also several housing providers who had “informal” processes to support individuals using substances.

“The parameters of harm reduction is determined by the TPA [Tenant Protection Act], therefore it is interpreted as reducing harm to the community of other tenants, e.g. quiet enjoyment, safety, security and protection from illegal or violent activity.”
(Toronto participant)

Using the rights and responsibilities outlined in this legislation ensured that tenants were held accountable to the same conditions as the general population rather than to an agency mandate. Further, as one Toronto housing provider noted, using the TPA also reduces conflict and misunderstanding, as *“workers and tenants have different perspectives on what harm reduction means.”*

Maintaining housing

Service providers linked the supports to housing stability back to prevention strategies, suggesting that maintaining housing and preventing returns to homelessness overlap with supports to prevent first housing loss. In both cases approaches to minimize the risk of housing loss must stress early intervention and mediation to prevent eviction.

“Helping people stay housed requires early intervention – building skills like paying rent on time, unit maintenance. There are real fears attached to this – life skills programs are needed to help build coping skills.” (Toronto participant)

Service providers spoke of the risks that accompany housing transitions and the need for supports to be sensitive to shifting needs and preferences. Tenants need support in determining the appropriate housing-support matrix and setting.



“People often jump from one supportive housing place to another. Many who start out in shared accommodation and move to individual accommodation soon ask to be switched back, citing loneliness and isolation.”

Providers noted that *“there needs to be more flexibility to allow for this [transition].”* Some suggestions for facilitating transitions and returns were probationary trials and flexible or phased supports. Some service providers felt that more transitional housing was the best option. Others felt that phasing of supports in the same housing site would minimize risk, allow supports to be responsive to changes and maximize continuity and trust. Flexible supports also recognize that the need for supports change over time and can be episodic.

Discrimination and access to housing and employment

Service providers did not feel that ageism was a factor in the provision of supports linked to housing, but acknowledged that it is an issue in the areas of employment and social recreational programs.

“Most of the community development is initiated by tenants over 50 and they help and teach the younger tenants. They implement and manage meal programs, clothing exchanges and community gardens but when they look for work the skills they have developed are not a match for the jobs offered.”

In addition to age related discrimination, other key challenges cited by the service providers were the lack of fit between the demands of service industry jobs typically available, the health and mental health issues many formerly homeless older adults experience, and the barriers imposed by income support programs.

One service provider suggested that an option for addressing the challenges to labour market participation might be to expand “internal employment” options, including facilitating age-specific social programs and self-employment through micro-enterprise. Another service provider suggested that one look to other jurisdictions that are successfully supporting



inclusion and healthy aging for models that could be adapted to the needs and preferences of formerly homeless older adults.

“It is important to look at other provinces for effective models – e.g., Victoria, B.C., has a large seniors population and a wide range of housing options. BC has also been very successful at forming partnerships with the private sector to build supportive housing – a better exchange of knowledge is necessary across provinces, across sectors and between service users and service providers.”

Several service providers were concerned with the increased stigma associated with poverty and recent systematic efforts to further marginalize and criminalize the poor. This was felt to be further exacerbated by the membership many of these older adults hold in a number of stigmatized groups in society (i.e., racial minority, formerly homeless, people with mental health issues, people that have been in conflict with the law).

“There is a trend to stop giving people on the street ‘stuff’: sleeping bags, food because there is a belief that it encourages people to stay on the street.”

“The recent motion to City Council to ban panhandling and take people off the street. To where? To jail? The issue is a huge lack of affordable, appropriate and accessible housing.”

Health and Well-being

Service providers stressed the importance of a range of health supports but singled out the “importance of affordable access to dental care.” Several service providers cautioned that although noticeable improvements were observed in day-to-day health, many tenants, once stably housed and able to access continued health care, have been diagnosed with serious conditions and are struggling with intensive treatment protocols. Many service providers spoke about the challenges in meeting the often complex health care needs of these older



adults as a result of many years of self neglect, lack of access to services and issues that are hard to separate out (i.e., mental health issues overlaid with alcoholism).

Two key areas cited by service providers as impacting the well-being of formerly homeless older adults were isolation and pervasive feelings of insecurity:

“Loneliness with a capital ‘L’ is a huge issue.”

“Older individuals are especially at risk – can be very isolated.”

Service providers noted that “bridges have been burnt” with other potential sources of social support (i.e., family and friends) stemming from long histories of dysfunctional relationships due to such issues as substance abuse and untreated mental health issues. Gender differences were highlighted by one service provider: *“many men are proud, stubborn and hesitant to accept traditional help, housing or social programs.”*

Many service providers spoke of the enduring insecurity and vulnerability reported by many formerly homeless older adults. Building a “health community” was endorsed as the best framework for issues around safety: *“community development regardless of housing type is key to health community.”* However, service providers recognized that high-risk sites may have to ramp up neglected physical and human security supports: *“security needs to be budgeted for, but is often left by the wayside.”*

In conclusion, service providers echoed many of the issues which emerged in the other data sources including: the lack of knowledge of available resources, the need to develop more direct access resources to finding housing and supports, the importance of clarity regarding the supports available on-site and referrals and advocacy in accessing community-based supports, the importance of life skills, tenancy skills and affordable trusteeships and pervasiveness of social isolation and loneliness. Like the research participants, service providers held divergent perspectives on the relative merits of clustering or matching tenants according to similar



characteristics. The service providers, much like the participants, stressed that attention to individual needs and preferences is key and a “like” community of tenants may be empowering for some but a cause of conflict to others.

Practice models suggested by service providers to address these key issues include continuity of support models with consistent support from homeless services to housing, city-wide life and tenancy skills programs that could accommodate tenants across the housing and support sectors, more affordable trusteeship programs that could mediate risk of eviction, models which assume that rental arrears are a “flag” for other issues and stress early communication with and intervention by housing/support workers, and housing and support models that emphasize “community building” or “community development” as a means of generating social capital and creating self-regulating tenant bodies. Another model raised by both service providers and research participants was need for more harm reduction housing and supports, so that active substance users are not excluded from housing.

Summary of Focus Groups #3

The third focus group in Toronto included 13 formerly homeless older adults who had participated in both the short structured survey interview and the longer semi-structured interview. In Calgary, focus groups were held at two of the main housing sites where participants were recruited into the study. There were 4 participants in the first group and 5 participants in the second group. Although the activities and discussions were similar to those of focus group #2, including the objective of validating early findings, the emphasis was on policy recommendations rather than practice-linked program recommendations as seen in the focus group with service providers.

Finding Housing

Many of the participants spoke of the stress of trying to find housing while residing in an emergency shelter where *“you’re all crowded in to together and it’s designed for the convenience of the staff.”*



Many participants also spoke of the stigma of having been homeless as a pervasive barrier to being able to secure housing.

“They don’t want homeless people in subsidized housing facilities, because we’re going to take advantage of those poor seniors and take all their money.” (Calgary participant)

“We’re treated as if we’re from another planet. It’s potentially the same thing. You don’t have an address, you come on dirty, you haven’t got a job, you’re from another ... try to apply for a card, forget it, yeah, you’re from another planet, speak a different language.” (Calgary participant)

The sheer lack of affordable housing was another barrier commonly discussed by the participants, particularly in the Calgary groups.

“The waiting list to get in there, hell, I might die of old age before my name every comes to the top.” (Calgary participant)

The age restrictions placed on accessing many housing facilities was a constant source of frustration for many of the participants as well, feeding into that whole notion of, “being too old to be young and too young to be old” that has been woven throughout the various narratives in the study.

“I go to four different groups around here trying to get housing. They say you’ve got to be over 60 in here, and I say I thought you had to be over 55? And they say, yes, but if you’re over 55 you have to have a physical disability...” (Calgary participant)

“Like I talked to you before about housing, it’s very hard to get before you are 60, any kind of subsidized housing or anything like that.” (Calgary participant)



Housing insecurity was also identified as a stressor by some participants, which has been shown throughout the findings in this study to impact the health and well-being of many of the participants.

“Well, I don’t want to rock the boat. I mean, I’ve got a room here you know. Maybe I’ll just hang on to that to the bitter end.” (Calgary participant)

“I got an eviction notice yesterday right under my door. It says your time’s up. You owe your rent, you’re three days over.” (Calgary participant)

Several participants commented on how the policies of the shelter system had a negative impact on their health. Although participants felt that their health had improved since securing housing, many commented on the lingering ill effects of having been homeless.

“When I was in the shelter system, I used to get sick a lot. Because you had people coming in, crowding, they’d start coughing, they wouldn’t cover their mouths...If you want any kind of medication you had to hand it in to the office. And then you had to go to the office when it was time get it; if you had to take it three times a day. You had to go to the office, take the medications...sign that you took it, this and that. Well, half the time the office door was closed. At least now, that I have my own place...you know, my health has improved a little bit...but I think that being outside on the streets at my age, I’ve got more aches and pains than I ever did.”

Continuity of support was emphasized by several participants as key to connecting with housing providers: *“intake workers who see them right along the process – see them right into their housing.”* Also, continuity of social support was mentioned by a participant who felt that maintaining contact with those people who were part of the social network while homeless would lessen feelings of isolation during the transition to housing: *“provide a community for them, programs, where they can come...they can share – with the same people that they knew from the homeless time.”*



“You get used to being in the shelter and you get a rapport and talk to a couple of people and then you might get into say a senior building. Now that senior building might have an office, maybe some staff but all of a sudden you’re taken from one – one scenario with people you know into a bachelor apartment by yourself.”

Alternative outreach that used informal information networks and peer support models and that was developed to encourage direct and user-friendly access was endorsed by many participants.

“You could post it on a piece of paper in all the shelters or have a web page for homeless people cause a lot of places have free internet access – a library has internet access. I know of lot of people who surf the Net, and, like I said, because we’re homeless but that doesn’t mean we’re dumb.”

“I’d like to see the, the development of a Blue Book, for specifically an aging population.. An aging population of perhaps between the ages of 45 and 65 that would be available at drop-ins and other community places.”

Many participants also spoke of the need for staff who fully understands the programs, services and housing options available to them in the community.

“I want to know if I have to go to a place, what I’ve got to do, what I’ve got to bring, who I’ve got to see, what kind of support I need so I don’t need to make 3 or 4 trips to the same place to get one thing, so OK, complete professional staff support. The reason why I say professional is a person who takes pride in their occupation and has the training to back it up. I didn’t mean a person who has a degree or certificate, but someone who has the background.” (Calgary participant)



Participants indicated a need for staff who are not only knowledgeable, but who are able to dedicate themselves on a full-time basis to working with them.

“There’s a resource worker that I know will help you, she will help to get you into these places, but there is only so much she can do, because she’s so busy doing a whole pile of other stuff, where if she was just doing that as her job, maybe there could be something going on.” (Calgary participant)

Participants repeatedly recognized “the hard work of being poor” and the remarkable and adaptive skills employed by the formerly homeless and homeless. The capacity and value of using peer workers was championed by many participants.

“They know how to get the cardboard boxes, put a layer of that on, they know where to hide their blankets and their sleeping bags or they carry it around all day, all day long, they’re carrying these heavy back packs, and they have to go from shelter to shelter and they don’t have bus fare. And they’re dragging the stuff around. This takes, takes all of their entire day.”

“And through the grapevine, street knowledge-you pick up a lot of things: where to get free clothes, free this, free that... and, and how to do it. You could get people like us who have this street knowledge and get them to input into the system.”

“At the X there’s one guy, he was the best worker there, he knew everything and could talk to everyone because he’d been in the hostels himself.”

Housing and Well-Being

Several participants spoke of the significant impact that securing housing had on their health and well-being.



“My health has greatly improved because now, I have a lot of choices. I can smoke indoors. I can go to sleep when I want to, I take naps...now, because I can sleep whenever I want to...and that’s another thing about being over fifty suddenly you’re tired...and you don’t argue it. Or if you’re sick you can go to bed. Yes, and then, gradually you find places where you get some decent clothes...and that makes you feel better, and, and there’s places where you can do free laundry, and you can get some decent food but even though you have housing you have to seek these out.”

“In a way, my diabetes, it’s better. And my cholesterol because I can have fruit salad. I can balance part of my meal when you have the money – at least for the first half of the month.” (Toronto participant)

The Challenges of Sharing Housing

Many participants spoke of the difficulties encountered in shared accommodation. Key areas of conflict include interactions with tenants who are actively using substances or who are struggling with poor mental health or who have poor life skills.

*“They don’t know any different. They have an attitude. When you tell someone to clean up after themselves and they turn around and tell you to go f**k yourselves, excuse me, what are you supposed to do? Duke it out with them because I’ve got a guy upstairs right now he will not, it doesn’t matter where you ... whatever sink he uses there’s water everywhere. I said to him, hey pal, can you clean up after yourself, you know, we all gotta live here? Who the f**k do you think you are, blah, blah, blah? So now I’m getting ready for the fists to start flying so is it worth it for me to continue this because we’re both gonna get thrown out for fighting?”* (Calgary participant)

“So you’ve got your one room and like in the middle of the night you have the washroom. But I got nervous, I had to like lock my door, you know go to the



bathroom, and then, I'd come and I'd lock my door, get back and stay wide awake here.” (Toronto participant)

“Like I'm not saying everybody is like that, but like I've lived in rooming houses where there's, you know, on drugs. They'd more or less just stayed in their rooms until they'd get rowdy. And overnight my door's locked.” (Toronto participant)

“There are more and more schizophrenics in our building. And we asked to have a kind of a course to be able to deal with them. Lucky, we have one, but the only way it helps us is to clarify that when you see a person you can identify that 'you're bipolar' or 'you're schizophrenic.' Well that's not what we were asking for – we were asking how to deal with it...” (Toronto participant)

However, a few participants felt that shared accommodation offered positive opportunities for support: *“I share, it's six, six of us on one floor... And, this is like a, this guy's, a gift from God, he's always cleaning and he's singing and he's cooking and he says, here do you want to try some of this, or, you know you're here – do you need a cigarette or something, he's a wonderful guy.” (Toronto participant)*

Although several participants felt that younger tenants were irresponsible, others felt that age segregated housing led to further isolation and to poor mental health.

“Another thing, about getting older – I find younger people really annoying. You know they're, they're, too loud, they're opinionated, and they don't really know much.” (Toronto participant)

“In the senior building...seniors have a tendency to keep to themselves. So here – you know you find yourself -you've got a roof over your head. But you have no outside... communication.” (Toronto participant)



Housing as a safe, secure haven

Housing as a site of safety and sanctuary was mentioned by a number of participants but most expressed persistent feelings of threat by other tenants, visitors and by “outsiders” in the community.

“But with the housing for me – what was the most important was the security. I’m at the top...I couldn’t be on the second floor, the third floor...I’d be scared to death. You know for me, that security is the most important, even before the health.” (Toronto participant)

Lack of adequate security mechanisms was the focus of many statements by participants.

“You call security for anything, like you’re lucky there, there in half an hour. Like you could be getting killed like and they’re just taking their sweet time. Like the area I’m in – it’s known for a lot of drugs – this and that. And you’ve got people that will let anybody in that building any time of night. And you’ve got, in the middle of the night, people banging on your doors. And you call security cause they’re waking everybody up at 4 o’clock in the morning and then when they know security is coming, they take off down the stairwell and they pull the fire alarm.” (Toronto participant)

“Like I have to go out every morning – six thirty and have to walk throughout a crowd of drug dealers. Well ... we have nothing in common, so they don’t bother me. But, they’re still trying to be intimidating. I just happen to be large – lucky me. But some people won’t go out, at all.” (Toronto participant)

However, one participant gave an example of “best practices” in building security: *“In our building – you can’t buzz people in, you have to go downstairs and let them in. And you have to go down with them when they leave too. And there’s a camera right there. And a*



security station right there, at the door. It is a cutting edge building and it is really good as far as security is concerned.” (Toronto participant)

Although security of person was highlighted by many participants, security of tenure was mentioned by several participants as critical to minimizing fears of returning to the streets. Supports to budgeting skills and trusteeships were mentioned as mechanisms to minimize risk of arrears and eviction, although both were felt to be limited by lack of funding for affordable access.

“And one of the big things with me – was trustee. Now there’s something I think some money should be spent on, it’s more trusteeships for people out there – and there is trusteeships but they have to be paid for. And people can’t afford to do it, I mean they’re out there spending all their money as it is... How are they going to pay for a trustee? But the trustee – I mean now, my rents paid, I have a roof over my head – any other bills I have... are paid for and then... if I go on and spend the rest at least I’ve got a roof over my head, and my bills are paid.” (Toronto participant)

The Fine Balance Between Independence And Support

Several participants referred to the importance of supports to sustain independence and self-determination. Participants described mechanisms for tenant participation available at various housing sites and linked them to enhanced feelings of control and autonomy.

“We have full reign on everything else to do with the building. We have input on every aspect of the building – with money coming in, how it’s going to be spent, type of thing.” (Toronto participant)

“We interview them...and everybody when they’re interviewed is always putting on best behaviour – you never know what will really happen.” (Toronto participant)



Other participants characterized the level of support as intrusive, referring to it as “surveillance”:

“It’s a dehumanizing thing, for people to have...be treated...with such scrutiny...when most of the time it’s not even necessary.” (Toronto participant)

“I had a friend here who got kicked out because he had a pipe here in his room...he said it was my pipe. The next thing I know, twice a week they’re in my room, they tear everything out of my room, they go through everything, they’re looking for something to do with drugs, and twice a week I need to go through that.” (Calgary participant)

Isolation

Several participants expressed frustration with the few opportunities for connecting with other tenants or community members, which was linked to both aging and mental health.

“And but the other part which I find it’s a bit harder...is first I’m sixty.. I cannot work anymore. And that’s the part you go more in depression because you’re stuck. I cannot go out. I’m stuck in my apartment. And sometime when you go in depression then health wise, you don’t give a damn.” (Toronto participant)

For me to get my needs met is really tough, ‘cause I don’t want nothing from nobody.” (Calgary participant)

Participants felt that peer-based mechanisms for getting connected would be useful and more responsive to the preferences of tenants.

“If there was a some kind of a system where if somebody’s coming from somewhere different, say a bachelor apartment in a senior building, that there’s a tenants rep or somebody could make it a point to go to the door and say: ‘Hi, my name’s Debbie, I’m



in apartment 612 or whatever – call me if you need anything’ or like just to get – some kind of a foot in the door for these people.” (Toronto participant)

Family

Family was identified as a “double-edged” sword in the Calgary focus groups. On the one hand, family was identified as a source of support, in terms of both social connectedness and instrumental support, as well as a source of pride:

“There’s someone here who tells me at least once a week how lucky I am to have my family come to see me.” (Calgary participant)

“Well, I depend on them and they look after me.” (Calgary participant)

On the other hand, family was identified as a source stress, anxiety, particularly the stigma of not being connected with one’s family:

“None of my family knows that I’m here...I don’t want them to know.” (Calgary participant)

“To me, family is like a job. If you don’t have family, you don’t have nothing.” (Calgary participant)

“When I used to call my family, my father would answer and say, “What do you want?” When he says, “what do you want”, not, “it’s good to hear from you, how are you doing, nothing...what do you want?” I want to say, “From you, nothing!” (Calgary participant)

“I have family, but they don’t come around here. I could be dying tomorrow and they wouldn’t come around.” (Calgary participant)



Supports to Independence

Identified as keys to not only finding but maintaining housing in Calgary, were addiction treatment services and life skills programs. A number of participants identified ongoing struggles with addictions and a lack of life skills as not only precipitating their fall into homelessness, but as an ongoing barrier to securing and keeping their housing once housed.

“I spent my whole life feeding my addictions. If it’s not cigarettes, then its booze, or its pot, or its codeine, or it’s sex....my whole life is run by my addictions...then how do I get the life skills?” (Calgary participant)

“See, I believe that a class for everybody called, “social intelligence”, how to get by in society. We’re not told that. We’re supposed to be innate to this, we’re supposed to know how to make decisions, and if we don’t...” (Calgary participant)

“I’m just wondering if they should make it compulsory to go to a life skills ... they should have life skills classes here ...” (Calgary participant)

“If you don’t get that complete support that it implies and you need where are you gonna start? How can you go? You can’t move forward, you’re just spinning your wheels.” (Calgary participant)

Social Exclusion

Participants offered a number of examples of oppressive policies and programs that they felt prevented them from fully realizing their potential. Participants felt the key to overcoming the limitations embedded in these policies was in adopting a client-centred, client-driven approach to policy making and programming.



“ I’d just like to add the necessity for the service users to be highly involved in making these types of decisions. I think the largest problem we face is the fact that every individual, every situation is different.” (Toronto participant)

Assumptions by policy makers and providers were frequently described by participants as paternalistic, frustrating, and ultimately leading some people to “give up” and “give in” to dependence on service systems.

“You know, it depends on what you had before you were homeless. Like myself, I’ve only been here for almost a year and I don’t really want to get too complacent or I won’t be able to get back up there again.” (Calgary participant)

“There is another problem, employment wise: sheltered employment – I don’t believe in this at all. They just squeeze you to death. Actually, you’re paid very little but your work is worth a lot.” (Toronto participant)

“I find that they love this very much. They always say, oh you have mental health issues? Good, we will get you in the Chef Program. Get you to cooking. Everybody who has mental health problems get you to cooking. But hey, I’m just depressed – I’m not dumb.” (Toronto participant)

Some participants reported that challenging the system was difficult and that a complex “industry” of homeless and housing services stood in the way of change.

“Yeah, they’re, they’re enabling you to stay into the system...and not to – it seems like they want to keep you down...you know...That’s what it seems like to me...anyway. The whole fiscal spending system...I’ve talked to a lot of people, and they think once they go into shelters and stuff like that – they become complacent. You know...they rely on it...they don’t want to go and go on the rent...in their own place. A lot of people do –



but there are statistics that a lot of people don't want to ... rely totally on the system"
(Toronto participant)

"The system forces you into conforming to the model and the stigma they give you and you've got no choice. If you say something that's the truth, they won't believe you, or they mistrust you." (Toronto participant)

"It's like you're, you're eating the most unbelievable mish mash of very, very dull food...sometimes the food is rotten... because the stores donate it, and, and you're eating rotten fruit. The Xs are being subsidized per head – and they don't want, they don't want to reduce the number of people who come because each head means they're entitled to money." (Toronto participant)

Participants felt that "mainstreaming" housing, services and supports might normalize the experience of accessing supports.

"I suggest, give everyone a debit card, let them go where they choose. If they want McDonalds – let them go to McDonald's. If they want to go Kentucky Fried Chicken, let them go to the Kentucky Fried Chicken. Give them 10 dollars or 10 dollars goes on that card everyday. They get it swiped, they can eat with the normal people instead of bringing all of us together somewhere and making us feel like we're the freaks of society." (Toronto participant)

"But the reason I love my place is, it is one of those places, working class building, where most of them are paying, paying full rent, and I'm paying subsidized rent. No one knows, even the cleaning lady who does all of my repairs she doesn't even know, who is subsidized and who isn't." (Toronto participant)



Discrimination on the basis of being homeless, being formerly homeless and receiving income assistance was reported by many participants as limiting their social and economic participation and access to housing.

“It’s a big mistake – they try to stigmatize everybody...you know, we’re all substandard and we’re fed substandard food and live substandard lives.”

“Individuals who, who look down at us ... who serve us, they look down at us. They think they’re doing something good for us and they have an attitude about it. But it’s not always the case. There are some people that really have a good heart.” (Toronto participant)

“It has to be more strictly supervised – the quality of the food. They figure – oh they’re just a bunch of bums. Give ’em whatever. Give ’em some dog food. They won’t complain. You know they’re too complacent, they’re institutionalized... who cares.” (Toronto participant)

“They think there’s got to be something wrong with you, if you don’t have a place to live and something wrong with you if you’re not working. Try and find a place to live and the say - where did you live before? Well I’ve been on the street... Well okay, well just fill that in... then you never hear from them again.” (Toronto participant)

“You’re going to have to be dishonest, because if I’m coming up to you and I’m saying, yes ma’am, I just started a job for \$8.50 an hour, I’m a recovering alcoholic, I’ve been living on the streets for about a year and a half and then at the shelter. Can I come live in your house? Good luck!” (Toronto participant)

Securing housing was linked by one participant to empowerment and identity: *“And now, if you have an address, like at least you can proudly say where I’m living that I am a*



visible person, I'm actually a person that takes up space. And that is very powerful. Just very, very powerful." (Toronto participant)

"I think housing is very, very important. Whether you are just the same person – if yesterday you have no fixed address, and today you have an address...it's so much different. Everybody treats you different. The police treat you different, the health system treats you different.. everybody treats you different. Even the ODSP system that gives you the money treats you different." (Toronto participant)

Finally many participants expressed ongoing fears of economic insecurity fostered by inadequate levels of income assistance, punitive policies that act as a disincentive to employment and shifting or hidden entitlements.

"I'm starting ... I'm in my mid-50s now. If I got and talk to somebody else whose had a job most of their life and has a mortgage and, you know, dah, dah, dah and I tell them I'm homeless and they go what ... because I'm supposed to have my shit together at 50 or older, okay, I'm supposed to have my house nearly paid for, I'm supposed to have an RRSP." (Toronto participant)

"And they'll say, they say everything is on a need-to-know basis and we don't need to know. I mean from ODSP they supply so many different programs and they don't tell you anything about them. I had to find out by word of mouth from somebody else on the street." (Toronto participant)

"I don't have a lot of money so I have to go to these places where there's people I don't really like and some of them are so bad that I'll just skip a meal...I won't even eat...I'd rather go hungry." (Toronto participant)

"And X is saying: 'well there's nothing we can do – they have to pay for X' and if they don't have the money, they're on pensions, they're living in this squalor, terrible



conditions and nobody seems to be able to do anything about it.” (Toronto participant)

Participants from the third focus groups highlighted many of the issues expressed by the service providers, identified in the first exploratory focus group, and highlighted in the analysis of other sources of data, such as the challenges to accessing resources, and transitioning to housing. They also noted the challenges but also the benefits of shared or congregate living arrangements, and the importance of “building communities” within the housing site with supports that foster autonomy, self-direction, security, social connection and participation.

Policy implications identified by the research participants included more funding and support of informal and peer-based resources, long-term investment in recovery and employment support programs that are client-centred and value individual capacity, reform of income supports to reflect the costs of living and to remove disincentives to work, and mainstreaming supports to address the profound stigma associated with having been homeless, receiving income support and residing in social housing. Finally, participants stressed the need to increase the quantity and variety of affordable age-appropriate housing and support options available.

The following are key findings for the Toronto and Calgary focus groups.

Key findings

- More affordable and age-appropriate housing is needed that includes a broad menu of housing and support options situated in mixed housing sites with market rent and rent geared to income (RGI) units.
- Enhanced funding is required to ensure that supports are accessible to everyone, particularly in the areas of life skills, therapeutic, personal support and housekeeping services.



- Integrated service delivery (e.g., coordinated mental health, health and personal care), policy frameworks, and funding mechanisms are necessary to ensure seamless and coordinated housing and supports to health and well-being of formerly homeless older adults.
- Networks of support must extend to and institutionalize partnerships with off-site agencies, informal community networks, peer support programs and families.
- Housing and supports must stress social inclusion and the principles of community development, enhancing empowerment through participation and embedded in a rights and responsibilities framework.
- Adequate income supports and decent wages are critical determinants of the health and well-being of formerly homeless older adults. Income support programs must be client-centred, transparent, reflect the real cost of living, and eliminate punitive disincentives to work.
- Training, education and other employment supports, as well as volunteer opportunities, based on long-term commitment and investment in people's capacity are necessary to ensure that formerly homeless older adults are meaningfully engaged and valued.
- The current service paradigm does not represent a “goodness of fit” with the service delivery needs of formerly homeless older adults (i.e., currently waiting days or months to see a service provider). Service delivery must shift to reflect the realities of these individuals' lives.
- There is a need for more housing professionals; staff who are knowledgeable about the range of programs, services and housing options available to formerly homeless older adults and whose time may be solely dedicated to serving this population.



SECTION 4: DISCUSSION

Relevance of Research

The discussion, informed by the literature review, presents a synthesis of the four sources of data collected in this study as they relate to the primary research question: what are the health and housing outcomes for formerly homeless older adults? The primary question encompassed seven key objectives:

1. To better understand the characteristics and socio-economic status of older people who were once homeless;
2. To examine the extent to which older homeless people are recovering from health consequences once they are housed;
3. To identify the service, support, and housing needs of formerly homeless older adults, and the barriers and successes in current practice;
4. To determine the effective recovery supports/services/programs;
5. To describe the models that allow these programs to be effective;
6. To clarify the limitations of these models for older adults; and
7. To articulate policy, funding and program implications for government, service providers, and other community stakeholders.

In this section, the analyses of the questionnaire, the qualitative interview, the focus groups and the Personal Health Information (PHI) are triangulated to provide a clearer picture of the health and well-being of formerly homeless older adults. The data are integrated and clustered according to the relevant objectives listed above, with the exception of the last objective that will be addressed in the following section on recommendations. Results from both cities will be integrated in the discussion with important contrasts between the Toronto and Calgary participants highlighted. Overall, the results of the data analysis indicate that formerly homeless older adults are stably housed and are moving toward better health and well-being and greater social inclusion, but that serious barriers limit their ability to fully realize these transitions.



Characteristics and Socio-economic Status of Formerly Homeless Older Adults

The gender split in our sample accurately reflects the proportion of men to women in the homeless population. Although we had expected to see greater differences between men and women, there were, in fact, only two significant differences in the Toronto sample: more women scored in the range of “probable depression” than men on the GDS and men reported significantly more episodes of homeless over a lifetime than women. The average age was 57 (with no significant differences between men and women), which is well over the eligibility requirement of 50 set by the study and consistent with the literature which suggests that 50 is an appropriate demarcation of “old” in the homeless population. “Accelerated aging” was linked to “homeless effects,” which emerged as a central theme in both the qualitative and focus group analyses. Participants spoke of the stressful conditions of living without housing as having, not only immediate adverse impact on their health and well-being, but lingering effects that persisted once housed. Poor nutrition, trauma and lack of access to health care while homeless left participants feeling considerably older than their chronological age.

As anticipated, most of the participants were born in Canada and identified as “white,” although a significant minority identified as Aboriginal and South Asian. Outreach and recruitment to varied ethno-cultural communities remains a significant challenge and consequently the sample in this study considerably under-represents ethno-culturally diverse and aboriginal communities.

Most of the participants were single, divorced or widowed which mirrors the ratio typically evidenced in the homeless population (McDonald, Dergal & Cleghorn, 2004). Both male and female participants expressed considerable loneliness and disconnection in the qualitative interviews. The trauma of not being able to trust and build relationships, as a result of the experience of homelessness, was vividly captured in the qualitative data. Another phenomenon limiting participants capacity to “get connected” was the internalized stigma and shame many participants felt due to their homeless experience, their receipt of income assistance, the depth of their poverty, and their residence in social housing.



A number of participants had attended university or college, while the majority had some high school education or had completed high school. In both the analysis of the focus groups and the qualitative interviews, frustration was expressed by service providers and formerly homeless participants concerning the inappropriateness of the employment supports and the ageism that limits labour market participation. Recovery and employment programs were characterized as paternalistic and insensitive to individual needs and capacities. Ageism, coupled with episodic unemployment while homeless, seriously constrained the employment options for many participants. Also, other “homeless effects,” such as poor health and mental health and ongoing adaptation challenges to “normal” schedules after years of chaotic living without permanent housing, made it extremely difficult for some participants to secure employment. These limitations were particularly salient given that qualitative data revealed that the majority of participants did not see themselves as “retired” and were either actively looking for employment or were intending to do so in the near future.

Despite the desire for employment, only one quarter of the participants reported any income from employment in the previous six months and, of this group, the majority reported part-time or casual work. While unemployment was an issue in Calgary attributable to the reasons cited above, a larger percentage of the Calgary sample was employed full-time, reflecting the robust nature of the Alberta economy that may override out of necessity, the barriers to employment as a result of the stigmatization of this population.

Most participants who identified income sources in the previous month reported income from social welfare programs such as the Ontario Disability Support Program (ODSP) followed by Ontario Works in Toronto and from Assured Income for the Severely Handicapped (AISH) in Calgary, with a smaller group accessing other disability benefits and old age pensions in both cities.

In both the qualitative and focus group analyses, participants highlighted the struggles they experienced “making ends meet.” Frequent descriptions of choosing between paying the rent or eating and the prohibitive luxury of new undergarments or a fast food burger were a



clear indication that participants had moved along—but not off—the poverty continuum. The high proportion of participants who relied on food banks and meal programs in both cities was a testimony to the challenges of securing enough to eat. Although participants, through the use of food banks, meal programs and the groceries they were able to purchase, were largely getting enough to eat, the nutritional value of the food was poor.

The majority of participants in Toronto reported a yearly income for 2004 in the range of \$10,000 to \$11,999, well below the current Low Income Cut-Off for a single individual in an urban centre. The average yearly incomes in Calgary were slightly higher, with the majority falling into the \$12,000 to \$14,999, but still far below the LICO for a city of this size. Not only were the levels of income available through assistance programs seen as inadequate in meeting basic needs, program policies were characterized as “welfare or poverty walls” that were difficult or impossible to transcend. Disincentives to work such as the clawback of earned income, the possibility of losing disability status, or the loss of health benefits were all described as formidable barriers to employment.

The homeless histories emerging from the survey data indicated that more than half of the participants in both cities had been homeless more than once, with men reporting slightly more homeless episodes than women. The preponderance of episodic homelessness is well documented in the literature (Anucha, 2005). The high risk of returning to homelessness was evident in the qualitative and focus group analyses, where participants reported being precariously situated in terms of income, housing, health, mental health and social capital. A number of participants met the definition for “chronic” homeless, reporting five or more times homeless in a life time (McDonald et al., 2004). During the last episode of homelessness a much larger percentage of Toronto respondents were homeless for more than 5 years as compared with the Calgary respondents; more than a 5 to 1 ratio. This would seem to indicate that there is earlier intervention occurring in Calgary to alleviate the duration of homelessness. A reoccurring theme of the focus group and qualitative interview analyses was the critical need for early intervention, a theme substantiated by the literature attesting to the correlation between years homeless and the difficulty achieving positive housing outcomes. Considering



the high frequency of homeless episodes and the high proportion of chronically homeless participants, it is notable that the majority of participants reported being stably housed for 5 or more years in Toronto.

Health and Well-being of Formerly Homeless Older Adults

Health Status

Overall the health and well-being of formerly homeless older adults were improving relative to health indicators for the homeless older adults interviewed in 2004. However, their health was lower than similar indicators reported in general population surveys. Again, the double jeopardy of “homeless” and “accelerated aging” effects were limiting participants’ abilities to move toward better health and well-being. Formerly homeless participants, once stably housed, reported greater access to health care. Results from the survey data indicated that the Calgary respondents scored considerably lower on the physical health score yet were much less likely to have visited a physician’s office in the previous six months than their Toronto counterparts. As previously discussed, this may be attributable to a number of factors, including the fact that fewer had health cards and the shortage of physicians in Alberta as a result of the rapid population growth. Conditions that may have existed while homeless, but remained undiagnosed, will negatively influence measurements of health. In short, the identification and treatment of undiagnosed or latent conditions that occurred during homelessness impacted health and well-being outcomes long after moving into housing. In both the qualitative interviews and the focus group analyses, participants stressed that recovery from the experience of homelessness was ongoing, often captured as a multiplier effect where one year of homeless experience required several years of stable housed experience to heal.

Mental Health Status

The data collected in the questionnaire on the mental health status of participants presented a mixed picture. One scale (SF-12 MCS) indicated that formerly homeless participants scored somewhat lower than the homeless adults interviewed in 2004. Again, the



confound of latent diagnosis may explain the lower MCS scores of the formerly homeless group, who, once housed and linked with the health care system, may receive diagnosis and treatment for poor mental health. However, scores on a mood scale used to assess probability of depression (GDS) in older adults indicated much lower levels of probable depression in the formerly homeless group than the homeless comparison group. Scores on both scales, the SF-12 MCS and the GDS, indicated poorer mental health than evidenced in similarly aged adults in the general population.

Analysis of the qualitative data revealed that for many participants, poor mental health was an ongoing struggle but that it was “less despairing” than that experienced while they were homeless. An important paradox raised by several participants was the flawed assumption that proximity and access to support would significantly improve their ability to seek help. A mental health crisis was described as “not rational,” a process and state where the crisis itself prevented participants from seeking help. However, participants did express greater confidence that being housed facilitated earlier identification of imminent crises that would allow them to seek support to forestall a health crisis.

Several participants described “homeless effects” as lingering trauma adversely affecting their mental health, using terms similar to the clinical symptomology associated with Post Traumatic Stress Disorder. The magnitude of the trauma experienced during the homeless period also emerged as a key issue in the focus groups with service providers who spoke of isolation and exile as maladaptive responses to “homeless effects.” Service providers and formerly homeless participants spoke of the critical need for supports and services to be sensitive and responsive to the residual effects of the traumatic events experienced while homeless.

For some participants, struggles with poor mental health were exacerbated by substance misuse. Although scores on a measure of problem drinking (CAGE scale) for the formerly homeless were considerably lower than those scores of the homeless adults interviewed in 2004, the proportion scoring in the range of problem drinking was significantly



higher than that in general population surveys (CCHS, Statistics Canada, 2001). Alcohol misuse thus remains a problem for some formerly homeless older adults.

Although close to a third of the formerly homeless participants scored in the range indicating memory problems (BOMC scale), this was considerably lower than the proportion scoring in this range in the 2004 homeless group. Analyses from the service provider focus groups revealed that Alzheimer's Disease and other forms of dementia were much less common than mood and schizophrenic disorders. Again this may be a sampling effect due to the relatively "young" average age and better health of those older adults who were willing and able to participate in the interviews. The focus group participants did, however, indicate that it was much more difficult to separate out the effects of overlapping health issues such as cognitive impairment and alcoholism.

Well-Being

The analyses of the global ratings of life satisfaction revealed that barely more than half of the formerly homeless participants in Toronto and slightly less than half in Calgary reported satisfaction with their lives, a proportion lower than ratings reported in the general population (Lindsay, 1999). Perhaps more significant is the number of remaining participants who endorsed neutral or dissatisfied ratings for life satisfaction. A key theme emerging from the qualitative and focus group analyses is that housing ends "houselessness" but that much more is needed to bring people into wellness, inclusion and other positive dimensions associated with quality of life. Key areas participants identified as limiting quality of life were factors like isolation, loneliness, discrimination, internalized stigma and lack of opportunities for meaningful participation (within and outside of the labour market).

Scores on the measures of social isolation and networks indicated that formerly homeless participants were at considerable risk of social isolation and continued to rely heavily on service providers for support (though with notably more support from family and friends than the homeless group interviewed in 2004). A significant difference was found between housing types and risk of social isolation in Toronto. Interestingly, those residing in



supportive housing were at significantly greater risk of social isolation than those participants living in supported housing with use of community supports. This finding is contrary to much of the literature (Lum et al., 2005; Pynoos et al., 2004; Cannuscio, 2003), which suggests that the presence of onsite staff exerts a positive effect on social connection and interaction. However, these studies sample from the general population of older adults living in supportive and supported housing. Consequently, as Ridgeway and colleagues (1994) suggest, formerly homeless persons may have a greater need for privacy and self-determination and find staff intervention intrusive, which may undermine social connections. Another factor influencing this unexpected outcome is the selection bias that may result in formerly homeless older adults with greater needs and challenges being placed in supportive rather than more independent housing settings.

Although qualitative analyses from the focus groups and qualitative interviews revealed that many formerly homeless persons were connecting and reconnecting with family and friends, a significant proportion remained disconnected from their housing and neighbourhood communities. Many factors limiting social support were cited, including discrimination (e.g., for having been homeless, for residing in social housing, for receiving income assistance, for being labeled “hard-to-house”), shame, distrust, lack of age-appropriate venues for social interaction, crime ridden housing and neighbourhood environments, limited mobility, poor mental health, and prohibitive transportation costs. Many participants expressed frustration with funding and programming that undervalued social capital, commenting that the focus was on the measurable outcomes of employment supports and that supports to social inclusion and quality of life were neglected. Although feelings of insecurity and threat were frequently mentioned by participants, overall, the formerly homeless reported fewer violations of personal safety than the homeless older adults interviewed in 2004.

Health care utilization

Analyses of relevant sections of the questionnaire indicated that formerly homeless participants were using more primary health care than the homeless adults interviewed in 2004. Analyses of the survey section regarding use of acute care (hospital emergency



department visits) reported for the previous six months was similar for both the formerly homeless and homeless groups. However, analyses of the secondary data on the use of health care services by formerly homeless participants in Toronto before and after housing, indicated that the actual mean number of visits dropped significantly after being housed as did in-patient and day patient care. These changes suggest that housing may contribute to more stable health care for the homeless once they are housed. The changes also imply reductions in the cost of care for this group as a result of being housed, since ambulatory care and inpatient care are expensive health services. Further, findings from the secondary data analyses are consistent with the survey findings indicating that the overall health of the newly housed has improved compared to an earlier study of the homeless but below that for the general population.

Service, support and housing needs of formerly homeless older adults

Just over one half of participants reported finding out about and having received assistance applying for their current housing from a social service worker. However, a significant minority located and secured their housing by themselves or with the assistance of informal supports such as family and friends. The analyses of the qualitative and focus group data found that some participants stressed that having professional “allies” or “advocates” was essential to navigating the social service and housing systems, while others stressed the power and value of informal networks and resources. Many participants suggested that resources should be directly accessible to users and that those resources should be informed by peer knowledge. Peer-based resources that incorporate the “lived experience” of the homeless and formerly homeless persons were seen as more responsive and more accurate.

The primary finding across all the analyses is that there is a serious lack of affordable, age-appropriate housing and support options, which impacts both finding and maintaining housing. This is an issue of supply but also an issue of lack of variability in housing/support packages. Because of the very low vacancy rates in Calgary, respondents in supported housing were probably forced to live in very poor circumstances, which they flagged in the survey and confirmed in the focus groups and individual interviews. Participants indicated in both the qualitative interviews and the focus groups that a matrix of housing and support options was



critical to achieving a “good fit” between individual needs and preferences and living arrangements. Participants indicated that the degree to which a “good fit” was achieved influenced housing stability and health and well-being. No single model could adequately address the diversity of needs and preferences.

Another critical aspect of achieving “goodness of fit,” identified by both formerly homeless participants and service providers, was that the process must be client-directed. Self-determination and autonomy were highly valued by participants and were related to feelings of loss of trust and loss of control experienced while homeless. Distrust and a high need for autonomy, examples of “homeless effects,” were best addressed by models of service that were client-centred and stressed relationship building.

Although the analysis of the survey sections addressing current housing and supports was, for the most part positive, a few areas emerged where needs were clearly not being met. When asked whether their housing was equipped to assist people with impaired mobility, the majority of participants in Toronto reported living in housing without accessibility accommodations. This finding has significant implications to formerly homeless older adults’ abilities to age in place. The Calgary data painted a much different picture, with the majority reporting that their housing was equipped to deal with the challenges faced by those with mobility issues. This is a reflection of the much newer housing stock available in Calgary; including housing specifically designed to meet the needs of people as they move through the aging process. Of those participants who indicated linked supports and services, the three most significant areas of unmet need identified were transportation supports, special services for older people, and skills development. Transportation issues were identified as particularly relevant in the Calgary data, which is a city that is more geographically dispersed in relation to its population size and with a far less developed public transportation infrastructure than Toronto. In the analyses of the qualitative interviews and focus groups, participants frequently reported that they could not afford transportation to health care settings or meal programs and that many services were insensitive to the needs of older people (e.g., to slower mobility and diminished memory). For a great many participants identifying as “too old to be young and too



young to be old” (the demographic “gap”), age-appropriate services were even more difficult to obtain.

Another area that merited concern across data sources was the issue of shared living arrangements. Almost two-thirds of participants indicated they shared accommodation but the vast majority expressed a clear preference for self-contained units. The conflicts arising in shared living arrangements became especially troubling in housing sites where tenants were clustered according to similar health and mental health challenges. Although some participants felt that residing with tenants who shared similar challenges promoted greater understanding and acceptance, the majority of participants felt that diversity (of age, gender, ability, health and mental health status and of tenure [i.e., mixed subsidized and market rentals]) prevented “ghettoization.” Participants spoke of cluster housing settings as creating dangerously vulnerable and disadvantaged housing communities.

A number of participants reported feeling unsafe in their housing, and they identified criminal activity and inadequate security along with a fear of fellow tenants as key reasons for feeling unsafe. Building and personal safety emerged as major themes in the qualitative data, where participants expressed wanting to have unregulated guest visits but also feared that not screening guests was dangerous. Both service providers and participants felt that more than any single policy or intervention, security and safety were best supported by “community building,” which emphasized participation, inclusion and created self-regulating tenant communities

Effective Models that Support Health, Housing and Inclusion

The objectives of identifying effective programs and services, the models that allow these supports to be effective, and the limitations that inhibit their effectiveness for formerly homeless older adults are informed by the findings from the qualitative interviews and focus group analyses. As mentioned in the previous discussion section on housing and support needs, no single universal model was identified as most effective in supporting the health and well-being of formerly homeless adults. Although a number of models are identified below,



the most significant theme was that a broad menu of housing, health and support options must be available to meet a diversity of needs and preferences of older homeless people.

Client-Centred Models

A primary theme emerging from the qualitative analyses was that the processes of finding and maintaining housing and supports should follow a client-centred model of delivery. Participants spoke of the necessity for relationship building and establishing trust with housing and support workers. Sound client-worker relationships were described as critical to early intervention to prevent returns to homelessness. Client determination of housing/support packages was viewed by participants as central to securing a “good fit” without which housing instability might ensue.

Continuity Models

The theme of continuity of support was linked to the relationship building highlighted in descriptions of client-centred delivery models. In some cases this referred to continuity of support from shelter to housing and in other cases the focus was on continuity across moves to different housing settings. The former was viewed as contentious by both service providers and formerly homeless participants, with some describing the link made from the shelter to housing as highly effective, while others felt that it was undesirable, even traumatic, to maintain links to homeless services. However, almost all service providers and participants stressed that continuity across housing settings was critical to maintaining housing stability and health. Several mechanisms for continuity were suggested such as portable supports—for example case management—that were de-linked from any single housing site or, alternatively, developing off-site partnerships with community-based agencies that would travel with a person and act as an adjunct to linked housing supports.

Integrated models

Integrated team models, such as those outlined in the literature review, were championed as a means of providing layers of support in a coordinated seamless delivery. In



this model, coordinated interdisciplinary teams provide a combination of care across a number of housing settings, which may have some level of onsite staff or no housing-linked staff. Service providers emphasized the challenges to staff in supporting a diversity of needs in a single service setting, because of the scarcity of staff trained to support the mental health and personal care needs of aging formerly homeless tenants. Formerly homeless participants emphasized the challenges of negotiating fragmented, inaccessible service systems, where staff were either overwhelmed or inaccessible, a process exacerbated by the lack of support from a professional advocate.

“Housing First” Models

“Housing first” models, though typically associated with independent “low demand” housing with client determined community-based support, do not necessarily imply the absence of on-site staff. The essential distinction made by service providers and formerly homeless participants was that the housing was not contingent on the tenant accessing any particular support or meeting any standard outside of those demanded of all tenants (e.g., prohibition on criminal activities and on behaviours that interfere with reasonable enjoyment of other tenants). Both service providers and participants strongly endorsed a framework of universal rights and responsibilities as an appropriate tool for accessing housing and mediating conflict.

Harm Reduction Models

Harm reduction was seen by service providers and participants as an integral component of a “low demand” “housing first” models, which would ensure that active users, often the most vulnerable of homeless persons, were not excluded from accessing housing. However, service providers expressed concern that housing sites formally adopting a harm reduction model might be subject to unfair scrutiny and stigma, despite substantial evidence-based research attesting to the effectiveness of harm reduction approaches (Hunt, 2004; Marlatt, & Witkiewitz, 2002; Riley & O’Hare, 2001; MacPherson, 1999). As an alternative, service providers felt that a rights and responsibilities framework subjects tenants to the same



prohibitions on substance use enforced in the general population without the problems associated with formal sanction of harm reduction. However, such an “informal” model of harm reduction may mean that the supports associated with formal harm reduction are not available, such as service and supplies to support safer consumption.

Community Development Models that Stress Participation And Engagement

Formerly homeless participants spoke of the need to build healthy housing and neighbourhood communities. Community building was accomplished by programs that stressed participation in decision making. For example, participants and service providers spoke of tenant councils that addressed everything from social recreational programs to providing the first intervention in the event of risk of eviction. Self-regulating housing communities were valued for fostering social connections; enhancing feelings of security, safety and autonomy; as well as providing a mechanism for skill building transferable to other settings. An extension of skill building, described in the focus groups, was a housing model that was developing micro-enterprises within the housing community to support transitions to paid work and combat the ageism and other “isms” (e.g. ablism) confronting employment seeking formerly homeless older adults.

An integral component of community building models was that they engage and incorporate peer knowledge. Participants highly valued “lived experience” and spoke of “word on the street” (and in the drop-ins) as a vital and responsive resource. A central theme emerging in both the qualitative and focus group analyses was that formerly homeless older adults had a tremendous amount of knowledge and resources that could be integrated into programming, materials and policies affecting the homeless community.

Models that Emphasize Diversity and are Integrated into the “Mainstream”

Although some participants expressed a preference for “clustered” settings (e.g., to reside with people with similar mental health challenges), most participants endorsed diversity as desirable across age, rental status (subsidized and market rents) and health status.



Clustering was perceived as dangerous and described as “ghettoization” that induced conflict and vulnerability to victimization. Service providers were less clear on the subject of diversity versus clustering. Many providers felt that diversity was an valuable principle but difficult to implement i.e. selective placement may not always be possible and staffing to accommodate a diversity of needs was challenging.

A variant of the theme of diversity was that of “mainstreaming.” Many participants described the stigma and shame associated with accessing food banks and meal programs and with residing in social housing clearly demarcated from the rest of the housing in the neighbourhood. Integrating service, supports, and housing into the mainstream was identified by many participants as a way to reduce the stigma. Participants suggested a number of examples such as some sort of invisible proxy that could be used to buy food and meals in mainstream venues or community kitchens open to all members of the public with nominal or subsidized fees.

Models that Support Transitions

Formerly homeless participants were adamant that models of services, supports, and housing must support transition and be flexible to shifts in need and preferences. Participants wished to transition to different housing sites, toward better health, well-being and inclusion, and toward greater economic security. Many participants expressed frustration with models that assumed the status quo was sufficient and that “maintenance was progress.” However, participants were sensitive to the risk that models emphasizing transition may marginalize or adversely impact those persons who cannot or will not make those transitions, again suggesting that client-centred, flexible models would be able to accommodate both options.

Key Limitations that Limit the Effective Delivery of these Models to Formerly Homeless Older Adults

The focus group and qualitative interview analyses revealed key limitations to the delivery of the above models to formerly homeless older adults: “homeless effects”; accelerated “aging effects”; ageism, especially the special class of ageism confronting the



“demographic gap” pertaining to those 50 to 65 years of age; classism, “poverty or welfare walls”; and a profound lack of affordable age-appropriate housing and supports.

“Homeless effects” and “accelerated aging effects” are clearly influencing the ability of formerly homeless older adults to recover and to improve health and well-being. Consequently, health and well-being supports must be sensitive to these effects and adjust accordingly. For example, health interventions should stress recovery of nutritional deficits incurred over the homeless period or accommodate, without necessarily pathologizing, the lingering effects of trauma experienced while homeless.

The varied and pervasive forms of discrimination experienced by the older adults limited their ability to secure employment, and housing, and to realize meaningful social integration. Classism and all its variants, identified in the analyses by such phrases as “hard-to-house,” “welfare bum” and “living in the projects” (social housing), are critical barriers that housing and support models must overcome. One way that housing and support models can address these stigmatizing labels is to avoid “clustering” and “naming” disadvantage whether through ensuring diversity or ensuring that any disadvantage associated with a program is as invisible as possible.

Ageism, as is evident in the general population, seriously eroded the ability of formerly homeless older adults to secure employment. Ageism in employment-seeking was further exacerbated for this group by the “homeless effect” which created significant breaks in their employment history and/or made skill sets obsolete. These limitations were particularly significant for those participants who saw themselves as members of the “demographic gap” between 50 to 65 years of age who were actively seeking employment and not at all ready to retire. Participants reported feeling caught between the conflicting assumptions that they were too old to find employment in a competitive and ageist labour market yet were receiving income assistance related employment support programs premised on the expectation of future employment and the cessation of income assistance. Skill development, training, and employment support programs for formerly homeless older adults should be based on realistic



assumptions of labour market participation and options to exercise skills in volunteer settings. The issue of the invisibility of the demographic “gap” extended to other areas of programming and was seen by participants as a serious limitation to appropriate service delivery. Service models should adapt and accommodate what participants refer to as a group that is “too old to be young and too young to be old.”

“Poverty or welfare walls” were a serious impediment to formerly homeless older adults achieving greater economic security. Participants, despite receiving income assistance and housing subsidies, were still living considerably below established Low-income Cut-offs (NCW, 2006). The significant reliance on food banks and meal programs reported by participants indicates the depth of poverty that many formerly homeless older adults experienced. As reported in the discussion of the socio-economic status of formerly homeless older adults, income assistance was not only seriously inadequate, given the cost of living, but also presented formidable barriers to transitioning out of poverty (e.g., asset ceilings) and into employment (e.g., loss of health benefits). For formerly homeless older adults, who were subject to discrimination and persistent “homeless effects” and “accelerating aging effects,” income support programs that were designed to be temporary and residual were clearly inappropriate to their needs and challenges.

A final and significant limitation is housing and support models that assume a static level of support with no effective means for transition to other housing settings. Formerly homeless participants spoke of the desire to transition to other housing settings; many were looking for settings with more independence and less support while some required higher levels of support and more accessible accommodations. Some formerly homeless participants and service providers spoke of the need to accommodate higher levels of support in the earlier stages of housing, which may no longer be necessary as greater health and housing stability is achieved.

Although the most formidable barrier to housing transition is the scarcity of affordable, age-appropriate housing and support options, any available transfers were reported to be



problematic and inadequately supported. For example, both service providers and participants noted the vulnerability introduced in moving to new locations and establishing new supports. Portable or community-based supports were mentioned as mediating the risks to the social connections and housing stability associated with relocation. Other suggestions made by service providers were that transitions should be “trialed” and barriers removed so people could return to their original housing situation. For formerly homeless older adults, the risks to stability of health, well-being, and of housing associated with adapting to a new setting must be mediated by models that offer ongoing links to supports established prior to the move.

Summary of Significance of Findings

In summation, the most significant implications of these findings for practice, program development and policy-making are fourfold. First, the findings emphasize that it is critical that health, support, and housing programs are sensitive to “homeless effects” and accelerated “aging effects.” Recognizing and supporting recovery from the persistent trauma induced by these effects is essential to preventing formerly homeless older adults from cycling back to homelessness. Rapid intervention is critical and must support people as they make transitions and during the first years of housing. Second, developing and evaluating age-appropriate affordable housing and supports are of primary importance. However, the findings highlight that policy, programming, and research must be premised on social inclusion so that issues such as community integration, belonging, participation, overcoming discrimination and stigma, and other measures of quality of life can be addressed. Third, the findings reveal that the assumptions around income support and employment support for this group need to be revisited. There is a significant disconnect between expectations embedded in these programs and the significant barriers experienced by formerly homeless older adults. Fourth, the findings suggest that homelessness and former homelessness must be situated as points on the poverty continuum so that policy and programming do not address them as discrete or disconnect them from other socio-economically marginalized groups.



Links and Partnerships with the Homeless Community

Partnerships and relationships have been established with over 50 agencies in the Greater Toronto Area (GTA) and 18 in Calgary servicing homeless and formerly homeless communities. Many of these service providers participated in the focus groups and the final round table. Further links have been made through the advisory committee, whose membership includes key stakeholders in the homeless community. Information sessions have been conducted at more than twenty different housing sites in Toronto and 6 in Calgary with the objective of knowledge transfer to staff and tenants, as well as for recruitment of new participants.

Further outreach to service providers has taken the form of postings on “housing workers.ca”: a website and network for housing workers. Attendance at the City of Toronto’s Alternative Housing and Community Services meetings has afforded regular contact with housing providers and workers and ensured that the community is updated on the status of the project. Another key link to the homeless community was established through the Daily Bread Food Bank, which afforded access and communication with their more than 200 partner agencies.

Formerly homeless older adults participated in the focus groups and roundtables and also were members of a working group struck for the creative dissemination action project. Further, engagement with the homeless community occurred through attendance at various events, including the “House Party” hosted by the Toronto Disaster Relief Committee, an “All-Party Forum on Homelessness,” a National Housing Day of Action community forum to save federal funding for homelessness and the Calgary Homeless Awareness Week. These events raised the profile of the study and provided opportunities to engage with advocates, homeless and formerly homeless persons. Links with the international and national homeless community began at the World Urban Forum in Vancouver where organizations such as Homeless International and Slum/Shack Dwellers International were engaged in knowledge



exchange at various networking events and roundtables held to discuss issues of urban poverty, shelter and health.

With supplemental funding from the National Research Program of the National Homelessness Initiative, a working group was formed to creatively disseminate and animate the findings of “In from the Streets: The Health and Well-being of Formerly Homeless Older Adults.” The working group consisted of 9 formerly homeless older adults who participated in the Toronto focus group, along with the “In from the Streets” Research Coordinators.

The working group had two primary tasks: a postcard campaign and a speakers’ bureau. For the first action, the group created a large-scale poster/collage representing the research. The group interpreted the research findings to create a poster that depicts the transitions that occur from homelessness, to housing, to feeling a sense of “home.” The barriers and challenges to these transitions were also depicted to emphasize that the “paths” out of homelessness were by no means linear or direct. Instead, the transitions from homelessness to home are processes that have steps forward and steps back that differ for each person. The poster was then made into a postcard image with a statement on the reverse side promoting affordable housing and supports that fostered social inclusion for older adults. The intent of the postcard campaign was to raise awareness of the research findings and the actionable issues emerging from the study. Over the course of several weeks, the working group went to a large cross-section of local agencies and other settings frequented by homeless and formerly homeless people. The group collected signatures on 2500 postcards and engaged people in discussion of homelessness, housing and health. The postcards will be mailed to appropriate policy makers.

The second action was the development of a speakers’ bureau. The working group engaged two advocacy and awareness groups as peer consultants: The Dream Team (an advocacy group of consumer/survivors, many of whom have experienced homelessness, who use personal stories to highlight the critical need for and efficacy of supportive housing) and “Voices from the Street,” the Toronto Homeless Speakers Bureau (a group responsible for



raising awareness and educating the community about homelessness). The peer consultants provided training to the working group on crafting personal stories that would be integrated with presentations on the research findings. Presentations were made at, for example, a City of Toronto Municipal Committee Meeting, the Supporting Communities Partnership Initiative (SCPI) Action Day, the “In from the Streets” Toronto Roundtable, and the Centre for Addition and Mental Health (CAMH). The poster will also be displayed at the Canadian Association of Gerontology (CAG) Conference in Quebec City. The links forged with the peer consulting groups may allow members of the working group to transition to these groups at the close of this project. Also, the research findings shared with the two groups will provide new evidence for them to incorporate into their speaking engagements.

The actions of the working group were very favourably received, both in terms of the postcard campaign and speakers’ bureau. The working group’s impressive campaigning for signatures on the postcards exceeded all of our expectations. The various audiences that heard the speaker’s bureau were informed of the research but also had the opportunity to hear personalized accounts of what the findings represented to the research participants. For the working group and the coordinators, the actions provided the opportunity to work with the research findings in personalized and creative ways. The results of these creative activities were taken “into the streets” (and meeting rooms) to further disseminate the knowledge created in and by this project.



SECTION 5: CONCLUSIONS & RECOMMENDATIONS

Policy Recommendations

These recommendations result from the triangulation of multiple data sources from this study. Specific policy and program recommendations are made that best accommodate the health and well-being of formerly homeless older adults. Many of the recommendations, however, have program and policy implications for a wider constituency, such as the general population of older adults and the homeless. The recommendations are considered at the federal, provincial and municipal levels of government, with the recognition that many of the recommendations cross jurisdictions. In addition, provincial and municipal level recommendations are purposely outlined in broad strokes with the understanding of the diversity of regional and local policy contexts.

Recommendation #1

Develop more permanent, age-appropriate, and affordable rental housing. The limited supply of affordable and age-appropriate housing severely affects the ability of formerly homeless people to move on to greater or lesser degrees of housing support if and when their needs change. In addition to this, there are numerous older adults, homeless or not, in Toronto and Calgary who do not have access to affordable and/or supportive and supported housing at all.

Federal Implications

- Develop a national housing policy that is sensitive to local demands and represents at least 1 percent of the federal budget (Hulchanski & Shapcott 2004). New affordable rental housing strategies must be developed and current housing stock protected (e.g., with a permanent and adequately funded Residential Rehabilitation Assistance Program). Accountability mechanisms must be in place that make transparent how



many units are built and whether they are actually affordable to Canadians living in core housing need. Canada remains the only “developed” nation in the UN that does not have a national housing policy. Canada is a signatory to the Universal Declaration of Human Rights where Article 25 (1976) clearly outlines the right “... to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing...” According to the latest review, Canada has failed to meet its obligations in a number of areas. The federal government should acknowledge the conventions of the ESCR and its violations and begin work to address the shortfalls identified in the most recent UN review (Committee on Economic, Social and Cultural Affairs, 2006). In particular, the recommendation that calls on all levels of government to:

“...address homelessness and inadequate housing as a national emergency by reinstating or increasing, where necessary, social housing programmes for those in need, improving and properly enforcing anti-discrimination legislation in the field of housing, increasing shelter allowances and social assistance rates to realistic levels, and providing adequate support services for persons with disabilities. The Committee urges the State party to implement a national strategy for the reduction of homelessness that includes measurable goals and timetables, consultation and collaboration with affected communities, complaints procedures, and transparent accountability mechanisms, in keeping with the Covenant standards.”

- Renew and expand the National Homelessness Initiative’s (NHI) Supporting Community Partnership Initiative (SCPI). The NHI and SCPI have yielded significant outcomes for the homeless community and should become a permanent federal program. The current federal government should renew and expand both the level of funding and the eligibility to include the development of more permanent affordable age-appropriate housing and supports. Further, as outlined in an evaluation report of the Phase I SCPI program in Winnipeg (Leo & August, 2005),



the dilemma of supporting local determination within a framework of federal standards should be addressed through a performance approach rather than a regulatory framework. The report suggests that a clear statement of program objectives with a global performance measure, rather than detailed matrix of regulations, would allow for the integration of local expertise and national standards.

- Expenditures and funding for programs, housing, and supports must abandon a line-by-line-approach to budgeting in favour of inter-jurisdictional, cross-cutting funding (e.g., streamline access to federal funding for local governments similar to a horizontal initiative like SCPI). Horizontal funding frameworks, as strongly advocated for by the Federation of Canadian Municipalities (2006), recognize the vital role of municipalities in delivering programs and services that have largely been devolved from federal and provincial governments.
- Implement joint funding envelopes for support programs and services and capital costs, which will allow for more flexible and responsive programming. Joint funding envelopes will not only allow for more seamless and coordinated program delivery but will moderate the risk of one ministry bearing most of the costs while another reaps disproportionate benefits.

Provincial Implications

- Address the significant shortfall in the number of affordable housing units promised in the Affordable Housing Agreement Framework. According to the National Housing and Homelessness (NHHN) 2005 Report Card, most provinces have built far fewer homes than projected. Further, the NHHN (2005) reports that in some parts of the country, notably British Columbia and Alberta, provinces reduced their own housing spending and replaced it with federal dollars. Only Quebec has been able to achieve close to its target.



- Expand Housing Allowance programs and sanction municipalities to use shelter per diems to address immediate need in jurisdictions with higher vacancy rates. Provide rent supplements to appropriate candidates and allow access “in-situ,” so that individuals do not have to move in order to access a rent supplement. Evaluate and address the challenges in engaging private market landlords in Housing Allowance programs.
- Allow for discretion by social housing providers so that formerly homeless older adults, as well as “priority” groups, are able to access “senior” housing. For example, in Ontario build the discretionary power into the Social Housing Reform Act and into the municipal guidelines.
- Monitor and evaluate changes to the recently proclaimed *Ontario Residential Tenancies Act* and ensure that similar legislation in other provinces and territories does not contain any provision for default eviction. Establish or re-establish rent controls in jurisdictions where they are currently not available. As well, rent control should continue to apply even when a new tenant occupies the unit. For example, Alberta is one of only three provinces in Canada that has no rent controls in place. Moreover, Alberta’s tenancy legislation allows rents to be raised every six months for yearly tenancies and every three months for month-to-month tenancies. As a result of the flood of people moving into the province, particularly the City of Calgary, vacancy rates have dropped to less than 1.6 per cent, causing rental prices to soar. Evaluate the impact such legislation has on the availability of affordable age-appropriate rental housing stock and on prevention of homelessness. For example, CMHC’s yearly reporting on rental units should extend back further than the previous year to accurately capture trends in rental rates and vacancies (Ontario Tenants, 2003).
- Establish more affordable trusteeship programs for older adults in supportive housing to prevent eviction due to rent arrears.



- Develop homecare services targeted to the specific needs of formerly homeless older adults to support aging in place. The Health Council of Canada (2006) has recommended expanding the breadth of homecare, particularly in supporting chronic conditions. The Council stresses that current home care coverage excludes a number of groups and that issues of equity and diversity must be woven into home care delivery.
- Develop a framework that allows for cross-cutting coordinated initiatives between ministries. For example in Ontario, the Ministry of Health and Long-term Care, the Ministry of Municipal Affairs and Housing, and the Ministry of Community and Social Services should establish a mechanism to jointly address homelessness, housing, and supports.

Municipal Implications

- Expand private sector partnering in the development of social housing and integrate best practices from other jurisdictions. For example, western Canada's successful outreach to the private sector modeled on "social entrepreneurship" and American models such as Common Ground's "Affordable Housing Network" should be investigated and potentially replicated in other cities.
- Develop strong links to the Mayor's office on issues of housing, aging and homelessness by having representation from the Mayor's office at relevant committees and roundtables (e.g., in Toronto, the Seniors Roundtable, the Advisory Committee for Homeless and Socially Isolated Persons and the Alternative Housing and Community Supports Committee).
- Ensure that municipal planning and zoning by-laws protect existing affordable rental housing stock in the face of gentrification, condo conversion and redevelopment. Also, planning and zoning should promote the new development of affordable rental housing by moving toward increasingly more inclusionary zoning that combats



NIMBY-ism (“not-in-my-backyard”-ism) and reduces the need to engage in costly processes at municipal and provincial planning boards.

- Expand and enhance regulation of rooming houses, where many formerly homeless older adults reside, to meet the minimum housing standards.
- Expand upon models that partner landlords and housing workers in securing housing and providing supports, such as the “landlordconnect.ca” service piloted in Toronto, which links private rental market landlords and housing help workers with the objective of assisting people who are homeless or at risk of homelessness find and keep housing.

Recommendation #2

Develop more supports for older adults to age in place and to promote health and well-being. Affordable supportive or supported housing effectively allows older adults to age in place and reduces the use of and costs associated with institutionalization.

Federal Implications

- Consider and evaluate the need for a clearer policy framework to prevent “undue institutionalization” and to promote appropriate investment by all levels of government in community-based care and aging in place. The concept of “undue institutionalization” was comprehensively addressed by the United States Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999). The Ontario Human Rights Commission (OHRC) has raised the importance of measuring and monitoring the rate of unnecessary or “undue” institutionalization of persons with disabilities and other marginalized groups in order to safeguard the principle of integration over segregation (OHRC, 2004). Marginalized groups such as formerly homeless older adults are at high risk of “undue institutionalization” and require adequate protections and community-based supports to age in place. Further, this commitment



to aging in place must be matched by new funding to community-based supports and supportive and supported housing in an appropriate ratio to funding of long term care. Coyte and colleagues (2002) estimate that the supply of long-term care beds exceeds current needs.

Provincial Implications

- Recognize that housing and community-based supports contribute to the sustainability of the health care system and may moderate demand on more costly acute and institutional care if fully integrated into health care planning. This study's analysis of health care use suggests that supportive and supported housing is associated with reduced use of more expensive acute care. Also, recognize the critical role that community health centres, drop-in clinics, and mobile health services play in serving health needs outside of the formal health sector. These health services are especially vital to homeless, formerly homeless, and other marginalized persons who often rely on these settings. A first step is to make these services visible. Current health care utilization databases do not track these services but they should be included in these data files.
- Support Local Health Integration Networks (LHINs), and similar localized health care models in other provinces, in adopting a "social determinants of health" framework that recognizes the vital role that housing and supports play in the health care system, as identified in the Northwest LHIN Steering Committee consultations (2005).
- Remove barriers imposed by "health premiums." For example, in Alberta the current premiums are \$44.00 per month for a single person and \$88.00 per month for family coverage. As of October 2004 all persons over the age of 65, regardless of income, were exempt from paying Alberta Health Care Insurance Premiums as were persons receiving Assured Income for Severely Handicapped (AISH) benefits. Low-income non-seniors may qualify for premium assistance based on the previous year's taxable income, but it must be applied for. Therefore, many formerly homeless older adults and



socio-economically marginalized persons, not yet 65 or in receipt of disability benefits, would be required to pay all or part of these premiums. Given their precarious financial situation, the ability to pay these insurance premiums may serve as a barrier to accessing health care services. Ontario has similar premiums and should seriously evaluate their impact on socio-economically marginalized groups such as formerly homeless older adults.

Recommendation #3

Increase income support for older adults. The older adults who participated in this study had secured housing with rent geared to income, yet were still living well below the Statistics Canada Low Income Cut-offs (LICOs). Many are not receiving benefits, such as the GIS, AISH and ODSP, to which they are entitled and which would increase their monthly income. Income has clearly been identified as a determinant of health, as it provides access to not only housing, but also good nutrition and other necessities for good physical, emotional and social health.

Federal Implications

- Re-establish federal standards for income assistance, which were removed when responsibility was devolved to the provinces and territories, as a means of addressing the shortfalls outlined in the UN review statement above. However, care must be taken in developing a framework of equitable federal standards to recognize the principle of “subsidiarity” adopted by the European Union (Leo & August, 2005), which emphasizes that local expertise must drive local solutions.

Provincial Implications

- Reform income support programs as outlined in the UN recommendation above as well as remove punitive practices such as the high clawback rates of earned income and other disincentives to work, such as expediting reinstatement of disability status



if employment is terminated, ensuring continuity of disability benefits across episodes of institutionalization, and transitioning health benefits to early stages of employment. The National Council on Welfare's most recent report (2006) indicated that current welfare rates, as a percentage of the Low Income Cut-off (LICO), were just 24% in Calgary and 34% in Toronto. Disability benefits, though somewhat higher than general welfare, are still well below the LICO: 38% of the LICO in Calgary and 58% of the LICO in Toronto.

- Raise minimum wage to reflect the real cost of living or consider alternatives such as wage supplements (MISWAA, 2006). Alberta, until recently, had the lowest minimum wage in the country at \$5.90 an hour. For the first time since 1999, the minimum wage has been raised to \$7.00 an hour, still low by Canadian standards. A person in Calgary earning a minimum wage and working 40 hours a week earns \$1,213.33 per month, or \$14,560 per year. That is \$6,218 below the 2005 low income cut-off (LICO) of \$20,778 for a single person (NCW, 2006). In Toronto, the minimum wage is \$7.75 an hour. However, to fall within the limits of housing stability (the CMHC guideline of paying 30% of monthly income on rent) and pay average market rent in the city of Toronto for a bachelor apartment, a person would have to make a "minimum housing wage" of \$13.92 (Steve Pomeroy Focus Inc., 2005). In cities such as Calgary and Toronto, the high cost of living makes an adequate life on current levels of minimum wage untenable.

Municipal Implications

- Ensure that administration of income support and application processes are accessible and timely and that communication between income support workers and clients is clear, consistent, and transparent as to entitlements (e.g., how to access the special diet allowance or community start-up funds). In Toronto, consider extending the City Shelter fund to single adults, not just families, receiving income assistance.



Recommendation #4

Housing ends “houselessness,” but much more is needed to foster social inclusion for older adults who have been homeless. Acquiring housing was the first step to improved health and well-being for this group of older adults. With a roof over their heads, however, many respondents then found a “hidden ceiling” that limited their efforts to enhance their lives in other ways. Multiple barriers exist to social inclusion and serve to maintain exclusion, such as discrimination, lack of employment opportunities, and segregated social housing.

Federal Implications

- Anti-discrimination sensitivity training and policy reviews are necessary to remove all stigmatizing labels and language associated with homelessness, poverty (e.g., related to receipt of income assistance, to residence in social housing and to panhandling), ageism, and mental health status. Leadership at all levels of government to eliminate discriminatory practices, policies and terminology is crucial to formerly homeless older adults, and other marginalized groups, achieving greater social inclusion.
- Design affordable housing that avoids the stigmatization of poverty and promotes inclusive communities. Formerly homeless older adults, just as adults in the general population, prefer self-contained units with a diversity of tenants and rental arrangements.

Provincial Implications

- Expand and enhance employment support programs to ensure that individual capacity is considered and supported with long term investment and programming. Limited and short term programs do not adequately consider people’s employment and education histories nor do they provide the sustained support necessary to transition to the work force.



Municipal Implications

- Foster, support, and value long term volunteerism. Remove barriers to long term volunteerism that exist in the administration and organization of income assistance entitlements associated with volunteerism, where volunteers are inexplicitly moved around and not allowed to grow into their volunteer roles (e.g., eliminate premature terminations and reassignments of volunteer positions).
- Fund and support peer programs and resources that incorporate and value the lived experience of homeless and formerly homeless older adults. Informal information networks are responsive, flexible, accessible, and accurate ways to communicate what is available and how to access services.

Program Recommendations

Like the policy recommendations, the following program recommendations are based on the integration of multiple sources of data from the study. The specific program recommendations made are those that would best enhance the health and well-being of formerly homeless older adults. The recommendations are directed to local jurisdictions and the service providers who work in these jurisdictions. As a consequence, the recommendations are outlined as broadly as possible to accommodate the diversity of regional and local program environments

Recommendation #1

Incorporate generic guiding principles into the development of models of service delivery. It is important to reiterate that no single model emerged as “best” from the findings of the study. However, as outlined in Section Three, several models of service delivery emerged, providing a number of guiding principles that should be integrated into program delivery. Central to a discussion of models and program delivery is the core finding that



formerly homeless older adults must achieve the best possible “fit” for their needs and preferences in the context of a broad menu of housing and support options.

Implications

The following models and their underlying principles were identified as key to achieving that fit:

- Client-Centred Models that stress relationship building and establishment of trust;
- Continuity Models, where supports “follow” the people from shelter or street to housing and from one housing site to another;
- Integrated models that provide layers of support, both onsite and from the community, in a coordinated seamless delivery;
- “Housing First” models where housing is not contingent on the tenant accessing any particular support or meeting any standard outside of those demanded universally of tenants;
- Harm Reduction models, which can accommodate active substance users and support safer consumption with the understanding that some people will be unable or unwilling to participate in abstinence-based treatment programs;
- Community development models that stress participation and engagement in housing and neighbourhood communities, built on the value of peer supports;
- Models that emphasize diversity across age, tenure (mix of market rent and subsidized units), health and mental health status and are integrated into the “mainstream”;
- Models that support transitions by being flexible and responsive to shifts in needs and preferences.

Recommendation #2

Design new housing that accommodates the needs of older homeless adults to make aging in place possible. The design of new housing and the renovation and refurbishment of existing housing needs to take into consideration the needs of older adults, with special consideration of the needs of older adults who have experienced homelessness. In our study,



many respondents indicated dissatisfaction with issues such as air quality, privacy, cleanliness, and noise. Particularly in Toronto, respondents indicated a lack of devices that facilitated aging in place such as grab bars, wider doorways, and wheelchair accessible bathrooms. Issues of isolation within housing complexes, as well as safety issues, were raised as areas for concern in this study.

Implications

- Newer facilities must take design issues into consideration that attend to the eventualities of aging. One example is Peter Coyle Place in Calgary. Specific design considerations include wider hallways to facilitate the movement of people with mobility issues, thereby maximizing personal space. The dorm-style rooms that exist in this facility have higher than average ceilings to provide tenants with a greater sense of privacy and space, the facility has wider doorways to accommodate walkers and wheelchairs, accessible bathrooms with grab bars and call bells, and easy to use door closures.
- In order to facilitate interaction and access to staff, the staff offices need to be located throughout the facility on the floors where the tenants live. Interaction and socialization among tenants is facilitated through this type of design. Communal spaces need to be dispersed throughout the building with sitting areas on each floor, as well as a communal dining space that is also used for social activities between meals.
- In order to promote safety and make housing secure there is a need for greater security mechanisms, whether locks, entry buzzers, video cameras, and/or procedures and guidelines for entries and exits. Better still housing should be developed in the areas of communities which are free of crime.
- Although regulation of guest visits was suggested, many participants raised the condition that such regulation must not be too intrusive and must respect tenant autonomy. Serious reductions in the staffing of security guards were mentioned by



several participants. Housing design should include security measures that are effective without eroding tenant independence.

Recommendation #3

Enhance Mental Health and Addiction Services. The findings from our study and from the general research literature indicate that formerly homeless older adults frequently have long histories of mental health problems, often concurrent with substance abuse issues. Many of these individuals have experienced multiple losses throughout their lives, including family members, jobs, and financial support that may be compounded as a result of the aging process. As a result, they may experience a “ripple effect” from the culmination of these life course events that manifests itself in the form of anxiety, depression, low self-esteem and self-worth, as well as cognitive impairment. This may lead to self-destructive coping behaviours such as self-medication, alcohol, and other substance misuse. The mental health issues are often complex, overlapping, and, consequently, difficult to determine and treat. A direct consequence of the homeless experience and previous negative interactions with mental health and addiction treatment services is that these older adults may be mistrustful of the health and social service system and refuse to be involved with or accept assistance from service providers.

Implications

- The delivery of in-house mental health services as well as linking older adults with mental health problems to outside programs and services is an essential ingredient in not only finding housing for these adults, but also in keeping them housed over the long-term. There is clearly a need for linking both mental health and addiction services to more fully meet the complex needs of this group.
- Supports to develop feelings of security and trust are essential adjuncts to more formal mental health and addictions interventions. Security and trust can be enhanced by relationship building between service providers and tenants and by building healthy



“housing communities.” Community development style programming where tenants identify housing needs and steer interventions to meet those needs should be woven into traditional health supports.

- Program designs like Pears Avenue Housing Project in Toronto is an example of a housing provider that has recognized the need to partner with outside agencies in order to meet the complex needs of the their tenants. Modeled after the successful Common Ground Initiative of New York City, Pears Avenue has 15 offsite partner agencies (as well as onsite housing staff) that provide ongoing coordinated support to tenants. The Pears project year one outcome evaluation showed significant improvements in measures of tenant well-being (Jovcevska et al., 2006). Longitudinal evaluation of the health and well-being of tenants, such as that undertaken by Pears, would be of great value in assessing effective models of program delivery.

Recommendation #4

Create Flexibility in Housing and Service Delivery. Many of the participants, as well as service providers, in our study expressed frustration and concerns about the rules and requirements for both housing and participation in some programs. For example, funding regulations often dictate that someone must be of a certain age (i.e., 59 or older) in order to be eligible for certain housing options. The residual effects of homelessness mean that many of these individuals have experienced an accelerated aging process, whereby they may require the amenities and services that are available in some facilities tailored for older adults, but do not meet the chronological age requirement to access them. Some housing facilities also operated under a “zero tolerance” policy for alcohol and drug use that either prevented people from entering them in the first place or that put them at risk for losing their housing.

A related issue that arose was the requirement to participate in some treatment programs, such as the need to admit a substance abuse problem in order to be housed. These types of programs may be particularly appropriate for those individuals who have not been successful with the more traditional abstinence-oriented treatment programs and policies (Graham et al., 1994; West & Graham, 1999).



Implications

- Housing and programs should do away with age requirements.
- Given the unique life experiences of this population, programs need to be flexible in order to serve the needs of the members of this community. For example, some housing facilities have adopted a harm reduction model as opposed to a zero tolerance model, where the focus is on the harm that results from substance use as opposed to focusing on the substance use itself (Graham, Brett & Baron, 1994). Programs operating under a harm reduction approach see relapse as a normal part of the recovery process and tolerate continued substance use.

Recommendation #5

Make more use of case management services. Our own data, buoyed by the formal research literature, indicates a need for a case manager. As discussed throughout the study, the residual effects of homelessness and the aging experience itself often create the need for complex case management. A case manager is needed to serve as an advocate and liaison between older adults and all providers of their health care services. In today's health care environment, it can be overwhelming to navigate the system. Many older adults may not know all the questions to ask their service providers or they may not be familiar with the vast array of services available to meet their needs, as was evident in the findings. Many of the participants in our study reported using case management services and spoke of the benefits of this in the qualitative interviews.

Implications

- Case managers should bridge the gap between service providers and the older adult to ensure that all the information required to make well-informed health care decisions is available.



- Case managers should provide linkages to other resources and services to help ensure the health and social needs of older adults are met.
- Case managers should follow the older adult across all forms of housing, starting with emergency shelters.

Recommendation #6

Programming should address the “Age-Gap”. Participants in the qualitative interviews often commented on the need for programs and services that were specifically targeted to their age group (50-65). Many services and programs are targeted to either younger age groups (those under 30) or to older age groups (those 65 and older), particularly when it came to employment, social and recreational activities. As a result, this age group is at particular risk for “falling through the cracks” when it comes to service deliver and uptake.

Implications

- Programs need to be age relevant and take into account the issues of an older age group
- Service providers need to become aware of the issues special to the 50 to 60 age group.

Recommendation #7

Programming must include attention to transportation systems. Access to programs and services was an ongoing concern identified in both the survey data and qualitative interviews as to why people were not accessing services, having prescriptions filled, or following up with service providers after initial contact. Being able to access programs and services, especially when they are not provided on-site in the housing where people live, is an important component of the overall health and well-being of older individuals.



Implications

- Access means more than just providing a public transportation system; it also includes a system that is affordable and that enables people with physical challenges to access it. Several of the housing facilities where people were surveyed indicated that they were in the process of trying to secure their own vehicles for the purpose of transporting their tenants to and from appointments, for shopping, and to attend social and recreational activities off site.
- Some cities have special public transit for bus for older adults that take them shopping and home again, programs that could work for the formerly homeless.

Recommendation #8

Programming should monitoring financial abuse. Both the individual interviews and the focus groups raised concerns regarding the financial exploitation of formerly homeless older adults. A number of the people interviewed relayed long histories of family dysfunction. They spoke of visits from immediate and extended family members who would ask and pressure them for money, cigarettes, or alcohol. These requests also came from former friends and acquaintances from their days on the street and in shelters. Given the precarious financial situation of many of these individuals, financial abuse or exploitation is a serious concern.

Implications

- While the response to this issue has been for some housing facilities to restrict visitation or develop sign-in and sign-out policies to monitor guests, many participants felt this to be a form of control that limited their ability to interact and socialize with their family and friends.
- A program that allows for the discrete monitoring of individuals who may be at risk for financial abuse while still facilitating interactions with others and respecting autonomy should be considered.



Recommendation #9

Early Intervention to Prevent Eviction is required. Service providers must be vigilant to rental arrears as a “marker” of precarious housing and health. Service providers and formerly homeless participants spoke of rental arrears as a “flag” indicating that a person may be in need of support in other areas due to deteriorating health or mental health or the experience of loss or trauma. Many service providers clearly understood the connection between the threat of eviction and diminished health and well-being.

Implications

- Early intervention to avoid eviction is crucial.
- Processes to identify precarious housing and health are essential to preventing returns to homelessness.
- The arrears can be addressed through stepped or delayed payment plans or with referrals to resources such as provincial Rent Banks.
- Onsite money management support and training could be an effective alternative to formal trusteeships.
- Eviction should be considered only as a last resort. A few housing sites have adopted a policy of “no eviction” for rental arrears, recognizing that for formerly homeless older adults, eviction will almost certainly result in cycling back to the streets.

Recommendation #10

Provide education for service providers about “accelerated aging effects” and “homeless effects” to counter discrimination. Positive housing and health outcomes are best supported by staff that is sensitive and responsive to, and respectful of, the needs of aging formerly



homeless persons. Early education concerning the programs and services available may serve several functions. First, it may prevent people from falling into homelessness from the outset. Second, it may help to shorten the length and severity of the homeless experience. Third, it may help to further enhance the health and well-being of people once they are housed. Finally, it may help people to remain in a stable housing situation should they be at risk for losing it due to such things as income insecurity and poor financial management skills, problems with addictions, and mental health issues.

Implications

- Education about the array of programs, services, and housing options available to both current and former homeless older adults is essential in order to ensure that people are accessing and receiving care in a timely and appropriate fashion. Many of the people interviewed indicated that they had a very limited understanding of the services available to them prior to being housed and, to some extent, after securing stable housing. It often took a critical life event, such as being hospitalized, before some of these individuals became connected with the health and social service sectors.
- Education about homelessness for the sector providing services to the aged would enhance service.
- Education about aging for the homeless service sector would enhance service.
- In this study, public libraries were heavily utilized by our participants. This would be a natural venue for service providers to explore for not only educational purposes, but also for the actual delivery of services to the target population.

Recommendation #11

Programming must use and value peer resources. Participants stressed the value of informal networks and peer resources, which were described as responsive, flexible, accessible, and accurate. A number of service providers described mechanisms for engaging peers in supporting other tenants and in building health through “housing communities.”



Almost half of the participants found their current housing through informal networks (e.g., family, friends or directly through newspapers and directories, like the Toronto Blue Book).

Implications

- Tenant councils, tenant security guards, and tenant-driven supports and intervention were recommended for housing sites.
- Peer resources were relevant to community supports. Many participants spoke of “word on the street” as guiding them to appropriate services and programs. Informal communication networks should receive support from service providers and should be used by service providers.
- Resources should be directly accessible to users in a variety of traditional and non-traditional (e.g., local donut shops) settings and be informed by and presented by peers.

Recommendation #12

Enhance Public Awareness of homelessness and aging. Participants in the study consistently spoke of the stigma and marginalization they felt as a result of having previously been homeless, as well as the additional layers of stigmatization that were added as a result of gender, mental health, addictions, poverty, and age. This multiple stigmatization was not only discussed in terms of their own self-perceptions, but in their interactions with service providers and the public at large.

Implications

In order to provide a more inclusive living environment, both in the housing complexes and the broader community, an important component of any service provided is a broad educational campaign for all, to debunk the myths associated with older adults and create an understanding of the realities of their lives, including their strengths and the challenges that they face.



Areas for Future Research

As a result of the findings of this study and a review of the existing literature, the following are recommendations for future research:

1. Aging in place: How do marginalized older adults maintain their housing so that they can age in place? What health and social supports do they need as they continue to age and as their needs change? How well-equipped is the housing market to meet the demands of older adults aging in place (e.g., building accessibility, availability of age-appropriate housing, etc.)?
2. Homeless effects: When homeless persons are housed, this study found that the effects of homelessness are often profound and lingering (e.g., trauma, isolation). How pervasive are these effects? What exacerbates or minimizes these effects? How can formerly homeless persons best be supported in recovery from the negative effects of homelessness?
3. Eviction: Eviction prevention is a means of preventing homelessness for unstably housed individuals and families. How can eviction be prevented? How can eviction be used as an indicator of near homelessness and a foundation for intervention?
4. Models of Supportive Housing: An in-depth, evaluative study of housing models would contribute much to the literature on effecting housing supports for older homeless adults and others.
5. Community health care: This study identified prevalent use of health care services in informal settings, such as drop-ins. For marginalized groups, such as the homeless and formerly homeless, how much use is made of informal health care services (e.g. at drop-ins, mobile outreach units) versus acute care in formalized health care centres



(hospitals, clinics, etc.). The intent here is to gather data that is not otherwise recorded in health care utilization databases.

6. Diversity: This study did not capture diversity issues with regard to the formerly homeless. How do ethnic, racial, cultural and linguistic differences, as well as differences in ability, mediate the experiences of homelessness and finding and maintaining housing?



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SECTION 7: APPENDICES

APPENDIX A – COVERING LETTERS TO PARTICIPANTS

(Note: This sample letter is based on a template that was used for both Calgary and Toronto.)





Institute for Life Course and Aging

UNIVERSITY OF TORONTO

Carol Zoulalian
Director of Member Services
Houselink Community Homes
805 Bloor St West
Toronto, Ontario
M6G 1L8

Hello,

My name is Julia Janes and I am a Research Coordinator at the Institute for Life Course and Aging. The Institute is currently funded to conduct research investigating the experiences of older adults (50+), formerly homeless (experience of homelessness in the 2 years prior to securing supportive housing) and currently living in supportive or supported housing for 2 or more years. The leads are Dr. Lynn McDonald from the Institute (Toronto) and Professor Peter Donahue (Calgary). Both have extensive experience working with persons who are older and/or without housing and both express a keen interest in using the research as a driver of policy, particularly in the area of funding appropriate and affordable supportive housing for older adults. Issues of mental health area key component of the study but not an absolute criteria. I would be happy to expand on this brief backgrounder if your organization is at all interested in participating.

Ultimately, I am seeking your assistance in identifying prospective participants to interview (short and for some participants a longer interview and the potential to partake in a focus group to check the validity and relevance of the preliminary findings). An honorarium will be paid and interviewers will come on site or elsewhere as instructed by participants. I myself will come onsite to discuss the project and take contact information from interested tenants. In respect for the demands on staff time, I will do everything to ensure output by Houselink is minimal. Essentially, I would request that Houselink staff identify probable sites where eligible candidates may reside and grant me the time and space to conduct information sessions or less formal Q & As, where I would take contact information from interested residents.

It would be tremendous value to have Houselink and its residents involved in this project, which will highlight the vital importance of developing more supportive housing.

I look forward to hearing from you (if you would prefer to call me the # is 416-978-5616),

Julia

222 COLLEGE STREET • TORONTO, ONTARIO • M5T 3J1

PHONE: (416) 978-0377 • FAX: (416) 978-4771



APPENDIX B – CONSENT FORMS FOR PARTICIPANTS

Toronto Consent Form (short interview)

Title of Study: In from the streets: The health and well-being of formerly homeless older adults.

Principal Investigator: Lynn McDonald, Ph.D., Director, Institute for Human Development, Life Course and Aging, University of Toronto @ 416-978-7065

Co-Investigator: Peter Donahue, Faculty of Social Work, University of Calgary @ (403) 220-6711 pdonahue@ucalgary.ca

Research Coordinator: Julia Janes, Institute for Life Course and Aging, University of Toronto @ (416) 978-5616 aging.research@utoronto.ca

You are invited to take part in a study about the health and well being of older adults who were previously homeless but are now housed in supportive housing. This study is being conducted by researchers from the University of Toronto and the University of Calgary. This study is being funded by HRDC's National Homelessness Initiative. We plan to interview 250 adults aged 50 years and older about their experiences of homelessness and how these have changed since being housed, in order to better understand their situation and improve service planning and delivery. To be eligible, adults must be currently housed in supportive housing for two or more years. Prior to being housed, participants must have been homeless during the two years prior to securing housing.

I understand the following:

1. I will be interviewed for about one hour about my personal experiences, behaviours and feelings, and views about health and social services. My participation is completely voluntary. If I participate, I may refuse to answer any or all of the questions asked, especially if I am uncomfortable with any of them. I may end the interview at any time. When possible, private rooms will be available for interviewing, and if I agree, the interview can take place there. Otherwise, the interview will be conducted at a public location that I consider convenient, private, and safe for me.
2. My decision to participate or not, or to end the interview before the interviewer has asked all the questions, will not affect my access to any **housing or health services or any social services agencies**. The researchers will not consult any other sources of information about me; the only information collected about me will be what I provide and my health care utilization, *if I consent to the release of my OHIP data as indicated in a separate consent form*. If agency staff suggested that I might be interested in participating, they will not be told about whether or not I was actually interviewed.



3. My privacy will be respected and my responses will be kept confidential, **EXCEPT in those situations where I have volunteered information that the interviewer is required by law to disclose to the appropriate authorities (e.g. intention to cause harm to another person).**
4. **Because of the risks associated with revealing personal information (e.g. information that may indicate my involvement in criminal activity)** my name will not appear on the questionnaire. The completed questionnaire will be numbered and kept in a locked cabinet at the University while the researchers work with the information. All completed questionnaires will be destroyed within six years, and audiotapes within three months, of the study's completion. Any reports that the researchers prepare about this study will not identify me. **Any breaches in confidentiality could not be linked back to the me as my full name will only be recorded by the researchers, if consent is obtained, for the purposes of accessing health care utilization data. If consent is given to use my name for this purpose, it will only be kept for a brief interval in a locked cabinet at the University prior to submission to the Ministries of Health. The Ministries of Health will return health care data to the researchers without any personal identifiers including name.**
5. Although I may not benefit personally from the study, the results will help improve services for older people who are homeless or previously homeless. I may find it uncomfortable to talk about my experiences or feelings. As well, my behaviour and health may be a concern for the interviewer. I may be asked if my name can be given to **a staff member of the supportive housing agency** so that they can find me the appropriate help. However, I have the right to decide whether or not I agree to be referred to additional services.
6. I may ask the interviewer any questions I have about the study. And I am welcome to phone the Principal Investigator, Co-Investigator, or Research Coordinator (see names and phone numbers above) with any questions or concerns that I have about the study.
7. **If I have questions about my rights as a research participant, I can contact the Director of the Ethics Review Office, Rachel Zand, at 416-946-3389.**
8. My initials indicate that I understand and agree to participate in this study. I will receive a cash honorarium of \$20 in recognition of my time and valuable input if I participate in the interview. I will be required to initial a receipt with my name on it in order to receive the money.
9. I will receive a copy of this consent form to keep for myself.

Participant's initials: _____

Interviewer's initials: _____

Date: _____



Toronto Consent Form (long interview)

Title of Study: In from the streets: The health and well-being of formerly homeless older adults.

Principal Investigator: Lynn McDonald, Ph.D., Director, Institute for Human Development, Life Course and Aging, University of Toronto
416-978-7065

Co-Investigator: Peter Donahue, Faculty of Social Work, University of Calgary,
(403) 220-6711 pdonahue@ucalgary.ca

Research Coordinator: Julia Janes
Institute for Human Development, Life Course and Aging,
University of Toronto
(416) 978-5616 aging.research@utoronto.ca

You are invited to take part in a study about the health and well being of older adults who were previously homeless but are now housed in supportive housing. This study is being conducted by researchers from the University of Toronto and the University of Calgary. This study is being funded by HRDC's National Homelessness Initiative. We plan to conduct in-depth interviews with 50 adults aged 50 years and older about their experiences of homelessness and how these have changed since being housed, in order to better understand their situation and improve service planning and delivery. To be eligible, adults must be currently housed in supportive housing for two or more years. Prior to being housed, participants must have been homeless during the two years prior to securing housing.

I understand the following:

10. I will be interviewed for about two hours about my personal experiences, behaviours and feelings, and views about health and social services. My participation is completely voluntary. If I participate, I may refuse to answer any or all of the questions asked, especially if I am uncomfortable with any of them. I may end the interview at any time. When possible, private rooms will be available for interviewing, and if I agree, the interview can take place there. Otherwise, the interview will be conducted at a public location that I consider convenient, private, and safe for me.
11. My decision to participate or not, or to end the interview before the interviewer has asked all the questions, will not affect my access to any **housing or health services or any social services agencies**. The researchers will not consult any other sources of information about me; the only information collected about me will be what I provide. The agency staff who suggested that I might be interested in participating will not be told about whether or not I was actually interviewed.
12. My privacy will be respected and my responses will be kept confidential, **EXCEPT in those situations where I have volunteered information that the interviewer is required by law to disclose to the appropriate authorities (e.g. intention to cause harm to another person)**.



13. **Because of the risks associated with revealing personal information (e.g. information that may indicate my involvement in criminal activity)** my name will not be recorded during the interview. The tape and transcription of the completed interview will be numbered and kept in a locked cabinet at the University while the researchers work with the information. All transcriptions will be destroyed within six years, and audiotapes within three months, of the study's completion. Any reports that the researchers prepare about this study will not identify me. **Any breaches in confidentiality could not be linked back to the me as my full name will only be recorded by the researchers, if consent is obtained, for the purposes of accessing health care utilization data. If consent is given to use my name for this purpose, it will only be kept for a brief interval in a locked cabinet at the University prior to submission to the Ministries of Health who will return health care data to the researchers without any personal identifiers including name.**
14. Although I may not benefit personally from the study, the results will help improve services for older people who are homeless or previously homeless. I may find it uncomfortable to talk about my experiences or feelings. As well, my behaviour and health may be a concern for the interviewer. I may be asked if my name can be given to **a staff member of the supportive housing agency** so that they can find me the appropriate help. However, I have the right to decide whether or not I agree to be referred to additional services.
15. I may ask the interviewer any questions I have about the study. And I am welcome to phone the Principal Investigator, Co-Investigator, or Research Coordinator (see names and phone numbers above) with any questions or concerns that I have about the study.
16. **If I have questions about my rights as a research participant, I can contact the Director of the Ethics Review Office, Rachel Zand, at 416-946-3389.**
17. My initials indicate that I understand and agree to participate in this study. I will receive a cash honorarium of \$30 in recognition of my time and valuable input if I participate in the interview. I will be required to initial a receipt with my name on it in order to receive the money.
18. I will receive a copy of this consent form to keep for myself.

Participant's initials: _____ **Date:** _____

Interviewer's initials: _____



Toronto Consent Form (Ministry of Health Information)

Title of Study: In from the streets: The health and well-being of formerly homeless older adults.

Principal Investigator: Lynn McDonald, Ph.D., Director, Institute for Human Development, Life Course and Aging, University of Toronto
@ 416-978-7065

Co-Investigator: Peter Donahue, Faculty of Social Work, University of Calgary
@ (403) 220-6711 pdonahue@ucalgary.ca

Research Coordinator: Julia Janes
Institute for Human Development, Life Course and Aging,
University of Toronto @ (416) 978-5616
aging.research@utoronto.ca

You are invited to take part in a study about the health and well being of older adults who were previously homeless but are now housed in supportive housing. This study is being conducted by researchers from the University of Toronto and the University of Calgary. This study is funded by HRDC's National Homelessness Initiative. We plan to interview 250 adults aged 50 years and older about their experiences of homelessness and how these have changed since being housed, in order to better understand their situation and improve service planning and delivery.

In addition to the interview, the researchers would like your permission to access information about your use of health care services. We are asking for your consent to access your Ontario Health Insurance Plan information at the Ontario Ministry of Health and Long Term Care (if you live in Ontario) or your Health Care Insurance Plan information at Alberta's Ministry of Health and Wellness (if you live in Alberta). With this information we will be able to find out, for example, how much you have used the health care system, the types of services (hospital, physicians, ERs, etc.) and at what cost. This data will be linked to the information we gather from the interview to give us a full picture of health service use before and after you found supportive housing.

I understand the following:

19. My participation is completely voluntary.

20. My privacy will be respected and my health care information will be kept confidential. With the use of my name, gender, place and date of birth, the Ministries of Health in Alberta and Ontario can disclose my health care utilization information to the researchers for the period of time it takes them to work with the



data (one to two months). **Any breaches in confidentiality could not be linked back to me as my full name will only be recorded by the researchers, if consent is obtained, for the purposes of accessing health care utilization data. If consent is given to use my name for this purpose, it will only be kept for a brief interval in a locked cabinet at the University prior to submission to the Ministries of Health who will return health care data to the researchers without any personal identifiers including name.**

21. The data will be kept in a locked cabinet at the University while the researchers work with it. All data will be destroyed within six years of the study's completion. Any reports that the researchers prepare about this study will not identify me.
22. Although I may not benefit personally from the study, the results will help improve services for older people who are homeless or previously homeless.
23. I may ask the interviewer any questions I have about the study. And I am welcome to phone the Principal Investigator, Co-Investigator, or Research Coordinator (see names and phone numbers above) with any questions or concerns that I have about the study.
- 24. If I have questions about my rights as a research participant, I can contact the Director of the Ethics Review Office, Rachel Zand, at 416-946-3389.**
25. My initials indicate that I understand and agree to provide the researchers with my full name, gender, place and date of birth.
26. I will receive a copy of this consent form to keep for myself.

Full name: _____

Place of Birth: _____

Date of Birth: _____

Gender: _____

Unique Study Identifier: _____

Participant's initials: _____ **Interviewer's initials:** _____

Date: _____



Toronto Focus Group Consent Form

Title of Study: **In from the streets: The health and well-being of formerly homeless older adults.**

Principal Investigator: Lynn McDonald, Ph.D., Associate Director,
Institute for Human Development, Life Course and Aging
University of Toronto (416) 978-5968
lynn.mcdonald@utoronto.ca

Co-Investigator: Peter Donahue
Faculty of Social Work, University of Calgary
(403) 220-6711 pdonahue@ucalgary.ca

Research Co-ordinator: Scott McGrath
Institute for Human Development, Life Course and Aging
University of Toronto (416) 978-5616
aging.research@utoronto.ca

You are invited to take part in a study about the health and well-being of formerly homeless older adults. This study is being conducted by researchers from the University of Toronto and the University of Calgary. This study is being funded by HRDC's National Homelessness Initiative. We plan to interview 20 service providers (10 in Toronto and 10 in Calgary) about adults aged 50 years and older who are formerly homeless and currently housed in supportive housing to better understand their situation and improve service planning and delivery for them.

I understand the following:

1. I will participate in a focus group discussion for about 2 hours. The group facilitator will lead the discussion and take notes and/or audio-record the session if all the participants agree. My participation is completely voluntary. I may refuse to answer any or all of the questions asked. The focus group will take place at a time and location that I consider convenient and safe, which may be a social agency or a room at the University of Toronto, or a room at the University of Calgary.
2. First names will be used during the discussion; the audio recording and any notes taken by the researchers will not include my last name. The researchers may quote some of what I say in their report, but it will not be attributed to me by name. Group participants are asked to keep the discussion confidential, however, the researchers cannot guarantee that all participants will abide by



this request, and therefore they cannot guarantee confidentiality; they can only assure it to the extent that participants co-operate.

3. My privacy will be respected. The audiotapes will be transcribed and kept in a locked cabinet at the University of Toronto, or the University of Calgary while the researchers work with the information. They will be destroyed within three months of the study's completion.
4. Although I may not benefit personally from the study, the results will help improve services and program planning for older people who are homeless or at risk of being homeless.
5. I may ask the focus group facilitator any questions that I have about the study. I am welcome to contact the Principal Investigator or Research Co-ordinator (see contact information above) with any questions or concerns that I have about the study.
6. If I have questions about my rights as a research participant, I can contact the Director of the Ethics Review Office, Rachel Zand, at 416-946-3389.
7. My signature indicates my agreement and consent to be involved in this study.

Participant's signature: _____ Date: _____

Group Facilitator's signature: _____



Calgary Interview Consent Form

hi

Name of Researcher, Faculty, Department, Telephone & Email:

Peter Donahue, Assistant Professor 403-220-6711 pdonahue@ucalgary.ca
Faculty of Social Work, University of Calgary

Lynn McDonald, Director 416-978-7065 lynn.mcdonald@utoronto.ca
Institute for Human Development, Life Course and Aging - University of Toronto

Title of Project:

In from the streets: The health and well-being of formerly homeless older adults

Sponsor:

Human Resources Development, Canada - National Homelessness Initiative

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

Purpose of the Study:

You are invited to take part in a study about the health and well being of older adults who were previously homeless but are now housed in supportive housing. This study is being conducted by researchers from the University of Toronto and the University of Calgary. We plan to interview 250 adults aged 50 years and older about their experiences of homelessness and how these have changed since being housed, in order to better understand their situation and improve service planning and delivery. To be eligible, adults must be currently housed. Prior to being housed, participants must have been homeless or at risk for being homeless. You were identified as someone who may be willing to participate in this project by one of the staff members of your current housing project.

What Will I Be Asked To Do?

You are invited to take part in an in-depth interview to help us better understand your housing experiences. This interview would be audio-recorded with your permission. We will also ask a small group of people who participated in this study to take part in a focus group so that the researchers can present what they have found and see if you agree or disagree with our understanding of your experiences.

What Type of Personal Information Will Be Collected?

Should you agree to participate, you will be asked to provide some basic background information, such as your gender, age, cultural background, educational background, marital status, and income.

There are several options for you to consider if you decide to take part in this research. You can choose both, one or none of them. Please put a check mark on the corresponding line(s) that grants me your permission to:

I grant permission to be audio taped:

Yes: ____ No: ____

I grant permission for you to contact me in the future to take part in a focus group:

Yes: ____ No: ____

Are there Risks or Benefits if I Participate?

Your decision to participate or not, or to end the interview before the interviewer has asked all the questions, will not affect your access to any **housing or health services or any social services agencies**. The researchers will not consult any other sources of information about you; the only information collected about you will be what you provide. The agency staff who suggested that you might be interested in participating will not be told about whether or not you were actually interviewed.

Although you may not benefit personally from the study, the results will help improve services for older people who are homeless or previously homeless. You may find it uncomfortable to talk about your experiences or feelings. As well, your behaviour and health may be a concern for the interviewer. You may be asked if your name can be given to **a staff member of the supportive housing agency** so that they can find you the appropriate help. However, you have the right to decide whether or not you agree to be referred to additional services.

Your privacy will be respected and your responses will be kept confidential, **EXCEPT in those situations where you have volunteered information that the interviewer is required by law to disclose to the appropriate authorities (e.g. intention to cause harm to another person, child abuse)**.

There are no costs to you, other than the time it takes to participate in the study. You will be given a \$30 honourarium for your participation in the study that is yours to keep, even if you do not complete participation in the study.

What Happens to the Information I Provide?



Because of the risks associated with revealing personal information, your name will not appear in the interview. The completed interview will be transcribed and will be numbered and kept in a locked cabinet at the University while the researchers work with the information. All transcripts will be destroyed within six years, and audiotapes within three months, of the study's completion. Any reports that the researchers prepare about this study will not identify you. Any breaches in confidentiality could not be linked back to the participants because we will never have full names.

Signatures (written consent)

Your signature on this form indicates that you 1) understand to your satisfaction the information provided to you about your participation in this research project, and 2) agree to participate as a research subject.

In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from this research project at any time. You should feel free to ask for clarification or new information throughout your participation.

Participant's Name: (please print) _____

Participant's Signature _____ Date: _____

Researcher's Name: (please print) _____

Researcher's Signature: _____ Date: _____

Questions/Concerns

If you have any further questions or want clarification regarding this research and/or your participation, please contact:

Professor Peter Donahue
Faculty of Social Work
(403) 220-6711, pdonahue@ucalgary.ca

If you have any concerns about the way you've been treated as a participant, please contact Bonnie Scherrer in the Research Services Office, University of Calgary at (403) 220-3782; email bonnie.scherrer@ucalgary.ca.

A copy of this consent form has been given to you to keep for your records and reference. The investigator has kept a copy of the consent form.



Calgary Survey Consent Form

hi

Name of Researcher, Faculty, Department, Telephone & Email:

Peter Donahue, Assistant Professor 403-220-6711 pdonahue@ucalgary.ca
Faculty of Social Work, University of Calgary

Lynn McDonald, Director 416-978-7065 lynn.mcdonald@utoronto.ca
Institute for Human Development, Life Course and Aging - University of Toronto

Title of Project:

In from the streets: The health and well-being of formerly homeless older adults

Sponsor:

Human Resources Development, Canada - National Homelessness Initiative

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

Purpose of the Study:

You are invited to take part in a study about the health and well being of older adults who were previously homeless but are now housed in supportive housing. This study is being conducted by researchers from the University of Toronto and the University of Calgary. We plan to interview 250 adults aged 50 years and older about their experiences of homelessness and how these have changed since being housed, in order to better understand their situation and improve service planning and delivery. To be eligible, adults must be currently housed. Prior to being housed, participants must have been homeless or at risk for being homeless. You were identified as someone who may be willing to participate in this project by one of the staff members of your current housing project.

What Will I Be Asked To Do?

You are invited to complete a survey that will take no more than one hour to complete. We will be asking a small group of people who complete the survey to take part in an in-depth interview to help us better understand their experiences. You may be asked to participate in this at a later date. This would require about one to two hours of your time, depending upon how much information you have to share with us. This interview would be audio-recorded with your permission. We will also ask a small group of people who participated in this study to take part in a focus group so that the researchers can present what they have found and see if you agree or disagree with our understanding of your experiences. We would also like to better understand your usage of health care services. We would like to ask for your permission to access your health care records so that we can understand how often you use health care services, the type of health care services you use, and the cost of these health care services. In order to do this, we will need permission to use your Alberta Personal Health Number.

What Type of Personal Information Will Be Collected?

Should you agree to participate, you will be asked to provide some basic background information, such as your gender, age, cultural background, educational background, marital status, and income.

There are several options for you to consider if you decide to take part in this research. You can choose all, some or none of them. Please put a check mark on the corresponding line(s) that grants me your permission to:

<i>I grant permission to be audio taped:</i>	Yes: ____ No: ____
<i>I grant permission for you to contact me in the future to take part in an in-depth interview:</i>	Yes: ____ No: ____
<i>I grant permission for you to contact me in the future to take part in a focus group:</i>	Yes: ____ No: ____
<i>I grant permission for you to use my personal health care number to track my health service usage</i>	Yes: ____ No: ____

Are there Risks or Benefits if I Participate?

Your decision to participate or not, or to end the interview before the interviewer has asked all the questions, will not affect your access to any **housing or health services or any social services agencies**. The researchers will not consult any other sources of information about you; the only information collected about you will be what you provide. The agency staff who suggested that you might be interested in participating will not be told about whether or not you were actually interviewed.

Although you may not benefit personally from the study, the results will help improve services for older people who are homeless or previously homeless. You may find it uncomfortable to talk about your experiences or feelings. As well, your behaviour and health may be a concern for the interviewer. You may be asked if your name can be given to **a staff member of the supportive housing agency** so that they can find you the appropriate help. However, you have the right to decide whether or not you agree to be referred to additional services.

Your privacy will be respected and your responses will be kept confidential, **EXCEPT in those situations where you have volunteered information that the interviewer is required by law to disclose to the appropriate authorities (e.g. intention to cause harm to another person, child abuse)**.

There are no costs to you, other than the time it takes to participate in the study. You will be given a \$20 honourarium for your participation in the study that is yours to keep, even if you do not complete participation in the study.

What Happens to the Information I Provide?

Because of the risks associated with revealing personal information, your name will not appear on the questionnaire. The completed questionnaire will be numbered and kept in a locked cabinet at the University while the researchers work with the information. All completed questionnaires will be destroyed within six years, and audiotapes within three months, of the study's completion. Any reports that the researchers prepare about this study will not identify you. Any breaches in confidentiality could not be linked back to the participants because we will never have full names.

Signatures (written consent)

Your signature on this form indicates that you 1) understand to your satisfaction the information provided to you about your participation in this research project, and 2) agree to participate as a research subject.

In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from this research project at any time. You should feel free to ask for clarification or new information throughout your participation.

Participant's Name: (please print) _____

Participant's Signature _____ Date: _____

Researcher's Name: (please print) _____

Researcher's Signature: _____ Date: _____

Questions/Concerns

If you have any further questions or want clarification regarding this research and/or your participation, please contact:

*Professor Peter Donahue
Faculty of Social Work
(403) 220-6711, pdonahue@ucalgary.ca*

If you have any concerns about the way you've been treated as a participant, please contact Bonnie Scherrer in the Research Services Office, University of Calgary at (403) 220-3782; email bonnie.scherrer@ucalgary.ca.

A copy of this consent form has been given to you to keep for your records and reference. The investigator has kept a copy of the consent form.

Calgary Research Participants Focus Group Consent Form

hi

Name of Researcher, Faculty, Department, Telephone & Email:

Peter Donahue, Assistant Professor 403-220-6711 pdonahue@ucalgary.ca
Faculty of Social Work, University of Calgary

Lynn McDonald, Director 416-978-7065 lynn.mcdonald@utoronto.ca
Institute for Human Development, Life Course and Aging - University of Toronto

Title of Project:

In from the streets: The health and well-being of formerly homeless older adults

Sponsor:

Human Resources Development, Canada - National Homelessness Initiative

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

Purpose of the Study:

You are invited to take part in a study about the health and well being of older adults who were previously homeless but are now housed in supportive housing. This study is being conducted by researchers from the University of Toronto and the University of Calgary. We plan to interview 250 adults aged 50 years and older about their experiences of homelessness and how these have changed since being housed, in order to better understand their situation and improve service planning and delivery. To be eligible, adults must be currently housed. Prior to being housed, participants must have been homeless or at risk for being homeless. You were identified as someone who may be willing to participate in this project by one of the staff members of your current housing project.

What Will I Be Asked To Do?

As someone who either completed a survey for this project or participated in an in-depth interview for this project, we would like to ask you to take part in a focus group so that the researchers can present what they have found and see if you agree or disagree with our understanding of your experiences.

What Type of Personal Information Will Be Collected?

Should you agree to participate, you will be asked to provide some basic background information, such as your gender, age, cultural background, educational background, marital status, and income. There is one option for you to consider if you decide to take part in this research. Please put a check mark on the corresponding line(s) that grants me your permission to:

I grant permission to be audio taped:

Yes: ____ No: ____

Are there Risks or Benefits if I Participate?

Your decision to participate or not, or to end the interview before the interviewer has asked all the questions, will not affect your access to any **housing or health services or any social services agencies**. The researchers will not consult any other sources of information about you; the only information collected about you will be what you provide. The agency staff who suggested that you might be interested in participating will not be told about whether or not you were actually interviewed.

Although you may not benefit personally from the study, the results will help improve services for older people who are homeless or previously homeless. You may find it uncomfortable to talk about your experiences or feelings. As well, your behaviour and health may be a concern for the interviewer. You may be asked if your name can be given to **a staff member of the supportive housing agency** so that they can find you the appropriate help. However, you have the right to decide whether or not you agree to be referred to additional services.

Your privacy will be respected and your responses will be kept confidential, **EXCEPT in those situations where you have volunteered information that the interviewer is required by law to disclose to the appropriate authorities (e.g. intention to cause harm to another person, child abuse)**. As you will be taking part in a focus group with other people like yourself, we will ask everyone participating in the focus group to keep any information they hear about other participants to themselves. We will make sure everyone understand the importance of this and agrees to this at the beginning of the focus group. However, we cannot guarantee that other people in the group will not tell other people what people in the focus group said.

There are no costs to you, other than the time it takes to participate in the study.

What Happens to the Information I Provide?

Because of the risks associated with revealing personal information, your name will not appear on the transcripts from the focus group. The focus group audio tapes and transcripts will be kept in a locked cabinet at the University while the researchers work with the information. All transcripts will be destroyed within six years, and audiotapes within three months, of the study's completion. Any reports

that the researchers prepare about this study will not identify you. Any breaches in confidentiality could not be linked back to the participants because we will never have full names.

Signatures (written consent)

Your signature on this form indicates that you 1) understand to your satisfaction the information provided to you about your participation in this research project, and 2) agree to participate as a research subject.

In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from this research project at any time. You should feel free to ask for clarification or new information throughout your participation.

Participant's Name: (please print) _____

Participant's Signature _____ Date: _____

Researcher's Name: (please print) _____

Researcher's Signature: _____ Date: _____

Questions/Concerns

If you have any further questions or want clarification regarding this research and/or your participation, please contact:

*Professor Peter Donahue
Faculty of Social Work
(403) 220-6711, pdonahue@ucalgary.ca*

If you have any concerns about the way you've been treated as a participant, please contact Patricia Evans, Associate Director, Research Services Office, University of Calgary at (403) 220-3782; email plevans@ucalgary.ca

A copy of this consent form has been given to you to keep for your records and reference. The investigator has kept a copy of the consent form.

Calgary Service Providers Focus Group Consent Form

hi

Name of Researcher, Faculty, Department, Telephone & Email:

Peter Donahue, Assistant Professor 403-220-6711 pdonahue@ucalgary.ca
Faculty of Social Work, University of Calgary

Lynn McDonald, Director 416-978-7065 lynn.mcdonald@utoronto.ca
Institute for Human Development, Life Course and Aging - University of Toronto

Title of Project:

In from the streets: The health and well-being of formerly homeless older adults

Sponsor:

Human Resources Development, Canada - National Homelessness Initiative

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

Purpose of the Study:

You are invited to take part in a study about the health and well being of older adults who were previously homeless but are now housed in supportive housing. This study is being conducted by researchers from the University of Toronto and the University of Calgary. You were identified as someone who may be willing to participate in this project because of your work with older adults who have been homeless or who have been at risk for homelessness.

What Will I Be Asked To Do?

You are invited to take part in a focus group with other service providers that will take no more than two hour to complete. We would like to talk to you about what see as being the service, program and

housing needs of the identified population of older adults and your recommendations for service delivery and policy development in this area. We may contact you again to take part in a second focus group so that the researchers can present what they have found and see if you agree or disagree with our understanding of the issues facing this group of older adults and our recommendations.

What Type of Personal Information Will Be Collected?

Should you agree to participate, you will be asked to provide some basic background information, such as your gender, age category, occupational background, length of time working with the target population and educational background.

There are two options for you to consider if you decide to take part in this research. You can choose one, both or neither of them. Please put a check mark on the corresponding line(s) that grants me your permission to:

I grant permission to be audio taped: Yes: ____ No: ____

I grant permission for you to contact me in the future to take part in a second focus group: Yes: ____ No: ____

Are there Risks or Benefits if I Participate?

There are no anticipated risks to you participating in this research. The potential benefit to you would be access to the final results of the study which may help you to further develop programs and services for the identified group of older adults.

There are no costs to you, other than the time it takes to participate in the study.

What Happens to the Information I Provide?

Because of the risks associated with revealing personal information, your name will not appear on the focus group transcript. Identifying information will be removed during the transcription process. Data will be presented in aggregate form so that the information you provide cannot be linked to you. The focus group will be numbered and kept in a locked cabinet at the University while the researchers work with the information. All transcripts will be destroyed within six years, and audiotapes within three months, of the study's completion. Any reports that the researchers prepare about this study will not identify you. Any breaches in confidentiality could not be linked back to the participants because we will never have full names.

Signatures (written consent)

Your signature on this form indicates that you 1) understand to your satisfaction the information provided to you about your participation in this research project, and 2) agree to participate as a research subject.

In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from this research project at any time. You should feel free to ask for clarification or new information throughout your participation.

Participant's Name: (please print) _____

Participant's Signature _____ Date: _____

Researcher's Name: (please print) _____

Researcher's Signature: _____ Date: _____

Questions/Concerns

If you have any further questions or want clarification regarding this research and/or your participation, please contact:

Professor Peter Donahue
Faculty of Social Work
(403) 220-6711, pdonahue@ucalgary.ca

If you have any concerns about the way you've been treated as a participant, please contact Patricia Evans, Associate Director, Research Services Office, University of Calgary at (403) 220-3782; email plevans@ucalgary.ca

A copy of this consent form has been given to you to keep for your records and reference. The investigator has kept a copy of the consent form

APPENDIX C – INTERVIEW GUIDE AND INTERVIEW QUESTIONS

(Note: Toronto and Calgary used the same interview guide and survey questionnaire.)

Study of Formerly Homeless Older Adults

Qualitative Interview Guide

Survey Number (office use only)

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Date of Survey (dd/mm/yyyy)

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Survey Site: _____

Interviewer: _____

Demographics:

Gender

- 1 Male
2 Female
3 Other (_____)

Age

Population group

- 1 Aboriginal (e.g. Inuit, Metis, North American Indian)
2 Arab/West Asian (e.g., Armenian, Egyptian, Iranian, Lebanese, Moroccan)
3 Black (e.g., African, Haitian, Jamaican, Somali)
4 Chinese
5 Filipino
6 Japanese
7 Korean
8 Latin American
9 South Asian
10 South East Asian
11 White
12 other (specify) _____
77 don't know
88 not applicable

A I would like to start by asking you about your living arrangements

1. Could you describe your current living arrangements.

Probes:

- *How do you feel about your current living arrangements? About other residents/tenants?*
- *What sort of supports are available, do you feel comfortable asking for supports & how are they helpful to you?*
- *How do you feel about the rules you are asked to follow? Which rules, if any, do you think are unnecessary and why? Are there any rules you think should be in place but are not?*
- *How is conflict dealt with between staff and residents, between residents?*

2. What would be your ideal housing situation?

Probes:

- *Do you have a desire to improve your current housing situation?*
- *What do you need/like – number of bedrooms, yard, kitchen, laundry facilities, location: close to stores/work, privacy self-contained, supports?*
- *Have you explored other housing options?*

B Now I would like to ask you about your experience of homelessness before you moved into supportive housing.

3. How did it happen that you lost your housing or became homeless?

- *What was going on in your life just before you lost your housing*
- *What feelings do you recall having while living without permanent housing?*
- *How did others react/ behave toward you during this time?*
- *How was your health during this time? Your mood?*
- *What helped you get through this time? (e.g. inner strength, spirituality, humour, supportive people in your life etc.)*

4. How did you find your housing? (if the participant has been living in another supportive housing site prior to current explore this, too; transition from homeless to housed in supportive housing is key)

Probes:

- *What was going on in your life just before you applied/moved in?*
- *How did you first hear about it?*
- *What did you think when it was first described?*
- *How much control did you have over the process?*
- *Who was involved in making the application? What did they do that was helpful/not helpful?*



5. What ideas do you have about services that would better help older homeless adults find and keep housing?

Probes:

- *What was helpful to you?*
- *Where did you get information/support in finding your current housing?*
- *Was there anything that delayed or blocked you from finding housing?*

C. I would like to get a sense of how you spend the day and how that might have changed over time.

6. Tell me about your usual daily activities. What does your day look like?

Probes:

- *What do you do, where do you go, who do you interact with?*
- *How is your day to day health? Mood?*
- *Do you feel in control?*
- *Do you have any difficulties doing the things you want to do? Why?*
- *How do you see this changing in 2 or 3 years?*
- *How does it differ from when you were younger?*
- *What is your greatest concern about getting older?*

D. Next, I would like to ask you about the supports you have to help you out and the supports you provide for others.

7. Tell me about your family and whether they help you with your housing and health concerns?

Probes:

- *Do you have any children? Brothers or sisters? Other family?*
- *How frequently do you see or talk to them?*
- *How much support and what kind of support do you receive from your family?*
- *Is there anything you wish you could change about your family?*

8. Who else do you get support and help from?

Probes:

- *Friends, people you worked with, neighbours/residents, service providers, people from a church/temple/mosque you attend?*
- *What kind of support do they give to you? Do you feel comfortable asking for support? What is helpful?*

9. What kind of help and support do you give to others?

Probes:

- *Who do you give support to, how often and for how long?*
- *What kinds of support? (e.g. you lend them money, you help them with doing things, talk to them about their problems, spend time together)*



E. I would be interested in the services you might be aware of or use.

10. Could you tell me about any services or programs you know of for people who are around your age?

Probes:

- Which ones do you use yourself?
- What do you like and dislike about the service, program, or agency?
- Are the services you use now, different from those you used when you were younger?

F. The next few questions are about your finances.

11. What are your sources of income?

If respondent is aged 65 years or more, ask:

- Are you planning to (or do you) collect the Old Age Security, Guaranteed Income Supplement, CPP etc. ? If no, why not?
- What other sources of money you might get? Are you trying to collect them? (**for help with benefits participant might be eligible for see resource package)

12. How do you receive your money?

Probes:

- By cheque, by direct deposit, through a family member or friend, through a Substitute Decision Maker or Public Trustee

13. Do you share your income with any other people?

Probes:

- With whom? Voluntarily? For how long?

14. How do you feel about how much money you have now and for the future?

Probes:

- Does it meet your needs, can you buy the things you want or need? Do you worry about having enough money?
- How secure/confident are you that you will have enough money to keep you going in the future?

G. Finally, is there anything else that I haven't asked about that you'd like to add?

Thank you for your time!



Survey of Formerly Homeless Older Adults

Quantitative Interview Guide

2005

Survey Number (office use only)	Date of Survey (dd/mm/yyyy)											
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Survey Site: _____

Interviewer: _____

Please confirm all three criteria:

- 50 or older
- Lived in supportive housing for 2 or more years
- Experienced homelessness in the 2 years prior to living in supportive housing



INTERVIEW SCHEDULE OUTLINE

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1.0 Demographics

Since we want to speak with older people, let's start with your date of birth.

1.1 What is your date of birth?

(only those born before July 31, 1956 are eligible)

____ / ____ / 1 9 ____
day month year

1.2 Gender:

- 1 1 Male
1 2 Female
1 3 Other (_____)

1.3 Were you born in Canada?

- 1 0 No → (if no, skip to question 1.5)
1 1 Yes

1.4 Where in Canada were you born?

City/town/reserve Province
→ (skip to question 1.7)

1.5 Where were you born?

City/town/ Country

1.5a How old were you when you arrived in Canada? ____ (enter age)

1.6 What is your current citizenship status?

- 1 1 Canadian citizen by naturalization
1 2 Landed immigrant
1 3 Refugee Claimant
1 4 Other (specify)

1 77 don't know

1.7 What language do you speak most often?

1.8 What, if any, other languages do you speak on a regular basis?

1.9 What is your marital status?

- 1 1 single (never married)
1 2 now married
1 3 common law marriage
1 4 separated
1 5 divorced
1 6 widowed

1.9 What is the highest level of formal schooling you have completed?



- 1 no schooling
- 2 some elementary (grades 0-8)
- 3 completed elementary (grade 8)
- 4 some high school (grades 9-12 or 13)
- 5 completed high school (grade 12 or 13)
- 6 some trade, technical, college, business school
- 7 completed diploma/certificate
- 8 some university
- 9 completed university degree
- 10 masters or doctorate
- 11 other (specify)

77 don't know

1.10 What is or was your occupation when you last worked?

1.11 Which population group do you belong to?

(This information is collected to develop programs and services that are appropriate and accessible for all Canadians)

Mark more than one or specify in the "other" category if you prefer

- 1 Aboriginal (e.g. Inuit, Metis, North American Indian)
- 2 Arab/West Asian (e.g., Armenian, Egyptian, Iranian, Lebanese, Moroccan)
- 3 Black (e.g., African, Haitian, Jamaican, Somali)
- 4 Chinese
- 5 Filipino
- 6 Japanese
- 7 Korean
- 8 Latin American
- 9 South Asian
- 10 South East Asian
- 11 White
- 12 other (specify) _____
- 77 don't know
- 88 not applicable



2.0 Experience of Homelessness and Aging

Now, tell me a little about YOUR experiences.

2.1 Have you ever in your life been homeless?

1 0 no (if no, probe further & if participant did not
experience homelessness prior to supportive
housing-end interview)

1 1 yes

1 77 don't know

2.2 At what age did you first become homeless? ____ (enter age)

1 77 don't know

2.2a How many times have you been homeless? _____

2.3 When were you last homeless? _____ year _____ month

2.3a How long were you homeless for ? _____ months/years
(length of the last time they were homeless)

1 77 don't know

2.3b After the last time you were homeless, when did you move into supportive housing?
_____ year _____ month

2.4 Have you ever stayed in a shelter? (could also be a detox or another type of residential treatment facility)

1 0 no

1 1 yes

1 77 don't know

2.5 At what age do you think a person who is homeless becomes "old"?* ____ (enter age)

*(some people think "old" is 65, others 60, 55 or 50; when do you think this occurs for someone who is homeless?)

1 77 don't know



3.0 Recent Housing History

Housing History

- I have a few questions about WHERE YOU LIVED BEFORE YOU MOVED INTO YOUR CURRENT HOUSING.

<p>3.1 What type of living arrangement did you have?</p> <p>1 supportive housing</p> <p>2 subsidized housing</p> <p>3 rooming/boarding house</p> <p>4 self-contained apt/house</p> <p>5 friends/family</p> <p>6 nursing home</p> <p>7 old age/retirement home</p> <p>8 long-term care</p> <p>9 hospital</p> <p>10 jail or detention</p> <p>11 long-term shelter</p> <p>12 emergency shelter</p> <p>13 group home</p> <p>14 building (i.e. subway, bank)</p> <p>15 abandoned building</p> <p>16 park</p> <p>17 on the street</p> <p>18 other (specify_____)</p>	<p>3.2 Who were you living with?</p> <p>1 living alone</p> <p>2 with partner</p> <p>3 with children</p> <p>4 with roommate/s or friend/s</p> <p>5 with other family members</p> <p>6 other (specify_____)</p> <p>77 don't know</p> <p>88 not applicable</p>	<p>3.3 How affordable was your housing?</p> <p>1 very affordable</p> <p>2 somewhat affordable</p> <p>3 somewhat unaffordable</p> <p>4 very unaffordable</p> <p>77 don't know</p> <p>88 not applicable</p>	<p>3.4 *How long did you live in in this place?</p> <hr/> <p><i>*If participant is unsure interviewer to calculate approximate time based on the answers to these questions:</i></p> <p>What year did you move in? _____</p> <p>What year did you move out? _____</p>	<p>3.10 What was the main reason for moving out?</p> <p>1 couldn't pay the rent</p> <p>2 evicted</p> <p>3 better accommodation available</p> <p>4 other (specify_____)</p> <p>77 don't know</p> <p>88 not applicable</p>
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4.0 Supportive Housing

I have a few questions about where you're living now. Again, all the information you provide is strictly confidential (*absolutely no one associated with your housing, services or supports will have access to your responses*).

4.1 How did you hear about the place you are currently living in?

- 1 housing/case/social/outreach worker
- 2 nurse/doctor
- 3 friends
- 4 family
- 5 housing help service
- 6 advertisement (newspaper, magazine, radio, television, internet)
- 7 other (*specify*_____)

4.1a How long have you been living in your current housing?

(to help calculate use prompts from question # 3.4 in previous section)

4.2 What, if any, professionals/workers assisted you in finding your current housing?

- 1 housing/case/social/outreach worker
- 2 community centre staff/volunteer
- 3 shelter staff
- 4 drop-in staff
- 5 Calgary Housing Company/Treaty 7

Housing/

- Métis Urban Housing/Bethany Care
- 6 Toronto Community Housing Corporation (TCHC: formerly Toronto Social Housing Connections)
- 7 self
- 8 other (*specify*_____)
- 77 don't know

4.3 Where were you living when you made the application?

- 1 supportive housing unit
- 2 subsidized housing unit
- 3 rooming/boarding house
- 4 self-contained apt/house
- 5 friends/family
- 6 nursing home
- 7 old age/retirement home
- 8 long-term care
- 9 hospital
- 10 jail or detention

- 1 11 long-term shelter
- 1 12 emergency shelter
- 1 13 building (i.e. subway, bank)
- 1 14 abandoned building
- 1 15 park
- 1 16 on the street
- 1 17 other (specify_____)
- 1 77 don't know
- 1 88 not applicable

4.3a Approximately how long did you wait between applying for your current housing and being offered a unit?

Years_____ Months_____ Weeks_____

4.4 How affordable is your current housing?

- 1 1 very affordable
- 1 2 somewhat affordable
- 1 3 somewhat *unaffordable*
- 1 4 very *unaffordable*
- 1 77 don't know
- 1 88 not applicable

4.5 How many rooms do you have access to in your home?

number of rooms_____

4.5a Are any of these rooms shared?

- 1 0 no (if no, skip to question 4.6)
- 1 1 yes, some of the rooms are shared

4.5b Which rooms are shared?

- 1 1 kitchen
- 1 2 bathroom
- 1 3 living /common room
- 1 4 other (specify_____)

4.5c How many people share each of the rooms indicated above?

4.5ci	kitchen:	number of people_____
4.5cii	bathroom:	number of people_____
4.5ciii:	living/common room	number of people_____
4.5civ	other room (specify_____)	number of people_____

4.5d Who do you share each of these rooms with?

(indicate number category e.g "1" for partner that applies to each room in blank space)

- | | |
|--|-------------------------------|
| 4.5di kitchen_____ | 1 1 with partner |
| 4.5dii bathroom_____ | 1 2 with children |
| 4.5diii living/
common room_____ | 1 3 with other family members |
| | 1 4 with a friend(s) |

4.5div other room
(specify _____) _____
specify _____)

↑ 5 with other residents/tenants
↑ 6 other person (*please*

4.6 What do you have in your kitchen?

↑ 1 stove
↑ 2 fridge
↑ 3 microwave
↑ 4 cooking utensils (e.g. pots, knives)
↑ 77 don't know
↑ 88 not applicable

4.7 What do you have in your bathroom?

↑ 1 toilet
↑ 2 sink
↑ 3 shower
↑ 4 bath
↑ 77 don't know
↑ 88 not applicable

4.8 What do you have in your living room/common area?

↑ 11 table
! 2 chairs
↑ 3 couch/sofa
↑ 4 T.V.
↑ 5 Stereo/radio
↑ 77 don't know
↑ 88 not applicable

4.9 What is the environment like in the place where you live?

4.9a Air Quality	4.9b Cleanliness	4.9c Noise	4.9d Physical Space	4.9e Privacy
↑ 1 excellent	↑ 1 excellent	↑ 1 excellent	↑ 1 excellent	↑ 1 excellent
↑ 2 very good	↑ 2 very good	↑ 2 very good	↑ 2 very good	↑ 2 very good
↑ 3 good	↑ 3 good	↑ 3 good	↑ 3 good	↑ 3 good
↑ 4 fair	↑ 4 fair	↑ 4 fair	↑ 4 fair	↑ 4 fair
↑ 5 poor	↑ 5 poor	↑ 5 poor	↑ 5 poor	↑ 5 poor

4.10 Does your home have any special features to help people with physical problems?

4.10a Grab bars?	4.10b Emergency call button?	4.10c Wider doorways, space under counters etc.?	4.10d A Shower that you could get a wheelchair into?	4.10e Automatic Doors	4.10f Ramps at entry ways?
↑ 0 no	↑ 0 no	↑ 0 no	↑ 0 no	↑ 0 no	↑ 0 no
↑ 1 yes	↑ 1 yes	↑ 1 yes	↑ 1 yes	↑ 1 yes	↑ 1 yes
↑ 77 don't know	↑ 77 don't know	↑ 77 don't know	↑ 77 don't know	↑ 77 don't know	↑ 77 don't know

4.11 Are you able to smoke?

4.11a In your home?	4.11b In the common areas of the building?	4.11c In designated smoking areas?
↑ 0 no	↑ 0 no	↑ 0 no
↑ 1 yes	↑ 1 yes	↑ 1 yes
↑ 77 don't know	↑ 77 don't know	↑ 77 don't know
↑ 88 not applicable	↑ 88 not applicable	↑ 88 not applicable

4.12 Can you consume alcohol?

4.12a In your home?	4.12b In the common areas of the building?
↑ 0 no	↑ 0 no
↑ 1 yes	↑ 1 yes
↑ 77 don't know	↑ 77 don't know

4.13 Can you have friends/family over?

4.13a During the day?	4.13b Overnight?	4.13c Do you have to obtain permission or notify staff of daytime guests?	4.13c Do you have to obtain permission or notify staff of overnight guests?
↑ 0 no	↑ 0 no	↑ 0 no	↑ 0 no
↑ 1 yes	↑ 1 yes	↑ 1 yes	↑ 1 yes
↑ 77 don't know	↑ 77 don't know	↑ 77 don't know	↑ 77 don't know

4.13d Do you have to let staff know or request permission to come and go from your home?

↑ 0 no
 ↑ 1 yes
 ↑ 77 don't know

4.14 Can you keep pets?

4.14a Cats?	4.14b Dogs?	4.14c Small animals(e.g. hamsters), birds, fish?
↑ 0 no	↑ 0 no	↑ 0 no
↑ 1 yes	↑ 1 yes	↑ 1 yes
↑ 77 don't know	↑ 77 don't know	↑ 77 don't know

4.15 What sort of health services are offered where you live?

- 1 medical care (e.g. from a doctor/specialist or nurse/practitioner)
- 2 dental care
- 3 foot care (e.g. from a podiatrist)
- 4 eye care (e.g. from a ophthalmologist/optometrist)
- 5 mental health and addiction services (e.g. from a psychologist/psychiatrist, addictions counsellor or community worker)
- 6 case work (e.g. social worker, Assertive Community Treatment [ACT] team or Community Occupational Therapy Associates [COTA])
- 7 physiotherapy
- 8 diet/nutrition services
- 9 medication management
- 10 homecare (e.g. Community Care Access Centres [CCAC])
- 11 other (*specify*_____)
- 77 don't know
- 88 not applicable

4.15a Of the health services not offered where you live, are there any you would like?

(reference those NOT selected in 4.15)

- 1 medical care (e.g. from a doctor/specialist or nurse/practitioner)
- 2 dental care
- 3 foot care (e.g. from a podiatrist)
- 4 eye care (e.g. from a ophthalmologist/optometrist)
- 5 mental health and addiction services (e.g. from a psychologist/psychiatrist, addictions counsellor or community worker)
- 6 case work (e.g. social worker, Assertive Community Treatment [ACT] team or Community Occupational Therapy Associates [COTA])
- 7 physiotherapy
- 8 diet/nutrition services
- 9 medication management
- 10 homecare (e.g. Community Care Access Centres [CCAC])
- 11 other (*specify*_____)
- 77 don't know
- 88 not applicable

4.16 What supports are available where you live?

Support

- 1 assistance completing forms
- 2 advocacy (i.e. a person/group that speaks on your behalf, or takes action about issues relevant to you)
- 3 skills development/employment services (e.g. ESL, literacy, computer training)
- 4 transportation
- 5 tenant committees/councils (i.e. forums for tenants to provide input/feedback)
- 6 referrals to off site health and community services
- 7 ethnocultural services
- 8 special services for older people (e.g Personal Worker [PSW])
- 9 other (*specify*_____)
- 77 don't know
- 88 not applicable

4.16a Of the supports not offered where you live are there any you would like?

(reference those NOT selected in 4.15)

Support

- 1 assistance completing forms
- 2 advocacy (i.e. a person/group that speaks on your behalf, or takes action about issues relevant to you)
- 3 skills development/employment services (e.g. ESL, literacy, computer training)
- 4 transportation
- 5 tenant committees/councils (i.e. forums for tenants to provide input/feedback)
- 6 referrals to off site health and community services
- 7 ethno cultural services
- 8 special services for older people (e.g Personal Worker [PSW])
- 9 other (*specify*_____)
- 77 don't know
- 88 not applicable

4.17 What amenities are available from your housing provider?

- 1 meal services (meal program or congregate dining)
- 2 laundry services (offered by housing provider)
- 7 laundry machines (do you own laundry)
- 3 housekeeping services
- 4 social/recreation programs
- 5 church/temple/mosque services
- 6 other (*specify*_____)
- 77 don't know
- 88 not applicable

4.17a Of the amenities not available from your housing provider are there any you would like?

(reference those NOT selected in 4.15)

- ☐ 1 meal services (meal program or congregate dining)
- ☐ 2 laundry services
- ☐ 3 housekeeping services
- ☐ 4 social/recreation programs
- ☐ 5 church/temple/mosque services
- ☐ 6 other (*specify*_____)
- ☐ 77 don't know
- ☐ 88 not applicable

4.18 If recreation/social programs are offered, which ones are available?

(if no programs are offered skip to 4.19)

- classes,
- ☐ 1 exercise programs (e.g stretch or strengthening dance, walking)
 - ☐ 2 bridge, bingo, Euchre or other game sessions
 - ☐ 3 arts & crafts
 - ☐ 4 language learning or other general interest classes
 - ☐ 5 special events (e.g. dances, coffee socials, dinners
- etc.)
- ☐ 6 day trips
 - ☐ 7 other (*specify*_____)
 - ☐ 77 don't know
 - ☐ 88 not applicable

4.18a Which, if any, programs do you participate in?

- classes,
- ☐ 1 exercise programs (e.g stretch or strengthening dance, walking)
 - ☐ 2 bridge, bingo, Euchre or other game sessions
 - ☐ 3 arts & crafts
 - ☐ 4 language learning or other general interest classes
 - ☐ 5 special events (e.g. dances, coffee socials, dinners
- etc.)
- ☐ 6 day trips
 - ☐ 7 other (*specify*_____)
 - ☐ 77 don't know
 - ☐ 88 not applicable

4.19 How do you get your meals?

4.19a Breakfast	4.19b Lunch	4.19c Dinner	4.19d Snacks
<input type="radio"/> 1 I make my own meal	<input type="radio"/> 1 I make my own meal	<input type="radio"/> 1 I make my own meal	<input type="radio"/> 1 I make my own meal
<input type="radio"/> 2 I make my own meals with the help	<input type="radio"/> 2 I make my own meals with the help	<input type="radio"/> 2 I make my own meals with the help	<input type="radio"/> 2 I make my own meals with the help

of a personal support worker	of a personal support worker	of a personal support worker	of a personal support worker
4.19a Breakfast	4.19b Lunch	4.19c Dinner	4.19d Snacks
↑ 3 I make my meal together with the other residents	↑ 3 I make my meal together with the other residents	↑ 3 I make my meal together with the other residents	↑ 3 I make my meal together with the other residents
↑ 4 I eat in the congregate dining room	↑ 4 I eat in the congregate dining room	↑ 4 I eat in the congregate dining room	↑ 4 I eat in the congregate dining room
↑ 5 A meal programs in the building brings it to my room	↑ 5 A meal programs in the building brings it to my room	↑ 5 A meal programs in the building brings it to my room	↑ 5 A meal programs in the building brings it to my room
↑ 6 I go to a meal program outside of the building	↑ 6 I go to a meal program outside of the building	↑ 6 I go to a meal program outside of the building	↑ 6 I go to a meal program outside of the building
↑ 7 I don't eat	↑ 7 I don't eat	↑ 7 I don't eat	↑ 7 I don't eat

4.20 For those meals provided by your housing provider, how would you rate your enjoyment of the meals?

- ↑ 1 excellent
- ↑ 2 very good
- ↑ 3 good
- ↑ 4 fair
- ↑ 5 poor
- ↑ 77 don't know
- ↑ 88 not applicable

4.20a How well do the meals provided by your housing provider satisfy your dietary needs (diabetic diet, low sodium diet etc.)?

- ↑ 1 excellent
- ↑ 2 very good
- ↑ 3 good
- ↑ 4 fair
- ↑ 5 poor
- ↑ 77 don't know
- ↑ 88 not applicable

4.20b How would you rate the variety of foods provided, including foods that reflect the ethno cultural preferences of the residents (e.g. vegetarian)?

- ↑ 1 excellent
- ↑ 2 very good
- ↑ 3 good
- ↑ 4 fair
- ↑ 5 poor

- ↑ 77 don't know
 ↑ 88 not applicable

4.21 For those meals that you prepare/order yourself, where do you get the food?

- ↑ 1 buy groceries
 ↑ 2 friends bring food in
 ↑ 3 family bring food in
 ↑ 4 food delivery program
 ↑ 5 restaurant/take-out
 ↑ 6 food bank
 ↑ 77 don't know
 ↑ 88 not applicable

4.22 Do you find that you have enough to eat?

- ↑ 0 no
 ↑ 1 yes (*if yes skip to question 4.23*)
 ↑ 77 don't know
 ↑ 88 not applicable

4.22a If no, why not?

- ↑ 1 can't afford
 ↑ 2 unable to get out to buy groceries/go to
 restaurants
 ↑ 3 don't know how to prepare
 ↑ 4 physically unable to prepare
 ↑ 5 don't have appropriate facilities (e.g. stove, fridge,
 sink, pots etc.)
 ↑ 77 don't know
 ↑ 88 not applicable

4.23 How would you rate the quality of your interactions with staff ?

4.23a Your confidence in staff competence or qualifications	4.23b Amount of support provided by the staff	4.23c Access to staff support	4.23d Warmth and concern conveyed by staff	4.23e Independence & self initiative encouraged by staff
↑ 1 excellent	↑ 1 excellent	↑ 1 excellent	↑ 1 excellent	↑ 1 excellent
↑ 2 very good	↑ 2 very good	↑ 2 very good	↑ 2 very good	↑ 2 very good
↑ 3 good	↑ 3 good	↑ 3 good	↑ 3 good	↑ 3 good
↑ 4 fair	↑ 4 fair	↑ 4 fair	↑ 4 fair	↑ 4 fair
↑ 5 poor	↑ 5 poor	↑ 5 poor	↑ 5 poor	↑ 5 poor

4.24 How would you rate the quality of your interactions with other residents?

4.24a Interactions initiated by you or another resident (e.g. you invite someone to watch TV with you)	4.24b During group programs or events (e.g during recreation programs, tenant meetings)	4.24 While eating in a congregate dining room
↑ 1 excellent	↑ 1 excellent	↑ 1 excellent
↑ 2 very good	↑ 2 very good	↑ 2 very good
↑ 3 good	↑ 3 good	↑ 3 good
↑ 4 fair	↑ 4 fair	↑ 4 fair
↑ 5 poor	↑ 5 poor	↑ 5 poor
↑ 77 don't know	↑ 77 don't know	↑ 77 don't know
↑ 88 not applicable	↑ 88 not applicable	↑ 88 not applicable

4.25 How would you rate the frequency of your interactions with other residents?

4.25a Self initiated interactions:

- ↑ 1 daily
- ↑ 2 weekly
- ↑ 3 monthly
- ↑ 4 very infrequently to no interaction
- ↑ 77 don't know
- ↑ 88 not applicable

4.25b Interactions in the context of group support/programs/congregate dining:

- ↑ 1 daily
- ↑ 2 weekly
- ↑ 3 monthly
- ↑ 4 very infrequently to no interaction
- ↑ 77 don't know
- ↑ 88 not applicable

4.26 What do you like best about your housing?

4.26 What would you change about your housing if you could?

5.0 Use of Health Services

Now I will ask you about your health care.

5.1 Do you have a Health Card? 1 0 no 1 77 don't know
1 1 yes 1 88 not applicable

5.2 In the past six months, have you received medical care from a doctor or nurse from any of the following places? (Read categories and if "yes" mark frequency)

	No	Yes	5.3 If YES, how many times in the last 6 months?		
			1) Once	2) Twice	3) Three or more times
a. a hospital where you stayed at least 1 night	1 0	1 1	1 1	1 2	1 3
b. a hospital emergency room	1 0	1 1	1 1	1 2	1 3
c. a hospital outpatient clinic	1 0	1 1	1 1	1 2	1 3
d. at a drop-in centre	1 0	1 1	1 1	1 2	1 3
e. a community health center	1 0	1 1	1 1	1 2	1 3
f. a walk-in clinic	1 0	1 1	1 1	1 2	1 3
g. a private doctor's/specialist's office (not in a hospital or clinic)	1 0	1 1	1 1	1 2	1 3
h. an addiction treatment unit/centre	1 0	1 1	1 1	1 2	1 3
i. at home	1 0	1 1	1 1	1 2	1 3
j. other (specify _____)	1 0	1 1	1 1	1 2	1 3

5.4 In the last 6 months, have you received care from... (Read categories and if "yes" mark frequency)

	No	Yes	5.5 If YES, how many times in the last 6 months?		
			1) Once	2) Twice	3) Three or more times
a. a G.P. ('family' doctor)	1 0	1 1	1 1	1 2	1 3
b. a psychiatrist or psychologist?	1 0	1 1	1 1	1 2	1 3
c. a mental health nurse?	1 0	1 1	1 1	1 2	1 3
d. a social worker?	1 0	1 1	1 1	1 2	1 3
e. a physiotherapist?	1 0	1 1	1 1	1 2	1 3
f. a police officer?	1 0	1 1	1 1	1 2	1 3
g. a fire-fighter?	1 0	1 1	1 1	1 2	1 3

5.4 In the last 6 months, have you received care from... (Read categories and if “yes” mark frequency)	No	Yes	5.5 If YES, how many times in the last 6 months?		
			1) Once	2) Twice	3) Three or more times
h. an ambulance?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
i. an occupational therapist?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
j. a speech pathologist?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
k. a dentist or orthodontist?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
l. an eye specialist (i.e. optometrist/ophthalmologist)?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
n. a gynecologist/urologist?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
o. another type of specialist?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
p. a pharmacist?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
q. a dietician or nutritionist?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
r. other (specify _____)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

5.6 In the last six months, have you needed health care of any type, but had difficulty getting it?

☐ 0 no ☐ 77 don't know
☐ 1 yes ☐ 88 not applicable

5.7 If yes, was it because.... (read list and mark all that are applicable)

	No	Yes
a. not available in the area	<input type="radio"/> 0	<input type="radio"/> 1
b. not available at time required	<input type="radio"/> 0	<input type="radio"/> 1
c. waiting time too long	<input type="radio"/> 0	<input type="radio"/> 1
d. felt it would be inadequate	<input type="radio"/> 0	<input type="radio"/> 1
e. cost - can't afford it	<input type="radio"/> 0	<input type="radio"/> 1
f. didn't get around to it/didn't bother	<input type="radio"/> 0	<input type="radio"/> 1
g. didn't know where to go	<input type="radio"/> 0	<input type="radio"/> 1
h. transportation problems	<input type="radio"/> 0	<input type="radio"/> 1
i. language problems	<input type="radio"/> 0	<input type="radio"/> 1
j. dislikes doctors/afraid	<input type="radio"/> 0	<input type="radio"/> 1
k. discriminated against	<input type="radio"/> 0	<input type="radio"/> 1
l. decided not to seek care	<input type="radio"/> 0	<input type="radio"/> 1
m. didn't have a health card	<input type="radio"/> 0	<input type="radio"/> 1
n. other (specify _____)	<input type="radio"/> 0	<input type="radio"/> 1

5.8 Do you have an *active “Substitute Decision Maker” or “Power of Attorney [POA] for Personal Care” to make health care decisions on your behalf? (*inquiring about current status NOT if a person has a POA in place that is not yet active)**

- 1 0 no (if no, skip to question 5.9)
- 1 1 yes
- 1 77 don't know
- 1 88 not applicable

5.8a If yes, do you find this helpful?

- 1 1 very helpful
- 1 2 somewhat helpful
- 1 3 somewhat *un*helpful
- 1 4 very *un*helpful
- 1 77 don't know
- 1 88 not applicable

5.9 Are you supposed to be taking any prescribed medication now?

- 1 0 no → (if no, skip to question 5.14)
- 1 1 yes
- 1 77 don't know
- 1 88 not applicable

5.10 For medications that have been prescribed for you by a doctor...

	No	Yes
a. do you always take them as directed?	1 0	1 1
b. do you sometimes run out and do not refill prescriptions when you should?	1 0	1 1
c. do you sometimes lose your medicine?	1 0	1 1
d. do you sometimes forget to take your medicine?	1 0	1 1
e. are there sometimes when you can't afford medication?	1 0	1 1
f. are there sometimes when the store doesn't have your medication?	1 0	1 1
g. other (specify _____)	1 0	1 1
	1 77	don't know

know

5.11 Who is responsible for keeping and giving you your medication?

	No	Yes
a. yourself	1 0	1 1
b. a friend	1 0	1 1
c. supportive housing workers	1 0	1 1
d. external health care worker (nurse/pharmacist)	1 0	1 1
e. family	1 0	1 1
f. other (specify _____)	1 0	1 1
	1 77	don't know

5.12 Who reminds you to take your medication when it is time for you to take them?

No Yes

a. yourself	1 0	1 1
b. a friend	1 0	1 1
c. supportive housing workers	1 0	1 1
d. external health care worker (nurse/pharmacist)	1 0	1 1
e. family	1 0	1 1
f. other (<i>specify</i> _____)	1 0	1 1
	1 77	don't know

5.13 When your prescription runs out, who picks up the refills?

	No	Yes
a. yourself	1 0	1 1
b. a friend	1 0	1 1
c. supportive housing workers	1 0	1 1
d. external health care worker (nurse/pharmacist)	1 0	1 1
e. family	1 0	1 1
f. other (<i>specify</i> _____)	1 0	1 1
	1 77	don't know

5.14 Have you needed prescription medications in the last six months but were not able to obtain them?

1 0	no	→	(if no, skip to question 5.16)	1 77	don't know
1 1	yes			1 88	not applicable

5.15 If yes, was it because.... (read list)

	No	Yes
a. not available in the area	1 0	1 1
b. not available at time required	1 0	1 1
c. waiting time too long	1 0	1 1
d. cost - can't afford it	1 0	1 1
e. didn't get around to it/didn't bother	1 0	1 1
f. didn't know where to go	1 0	1 1
g. transportation problems	1 0	1 1
h. language problems	1 0	1 1
i. dislikes doctors/afraid	1 0	1 1
j. discriminated against	1 0	1 1
k. decided not to seek care	1 0	1 1
l. didn't have a health card	1 0	1 1
m. other (<i>specify</i> _____)	1 0	1 1
	1 77	don't know

5.16 Do you take over the counter medication(e.g. aspirin, Tylenol, ibuprofen, or cough/cold medicine)?

1 0	no (if no, skip to section 6)
1 1	yes
1 77	don't know
1 88	not applicable

5.16a What sort of over the counter medications do you take?

5.16b If yes, how often?

↑ 2 daily
 ↑ 1 occasionally
 ↑ 77 don't know
 ↑ 88 not applicable

5.16c For what purpose? _____

6.0 Use of Community Services

The next few questions are about your use of community services.

6.1 In the past 6 months, have you used any of the following services either available in your building or in the community?

(Read categories and if “yes” mark location & frequency of services)

	No	Yes	6.2 If YES, where?	6.3 If YES, how often?		
				1) Once	2) Twice	3) 3+
a. drop-in centre to socialize?	↑ 0	↑ 1	↑ 1 in my building ↑ 2 in the community	↑ 1	↑ 2	↑ 3
b. drop-in centre/meal program to get a meal?	↑ 0	↑ 1	↑ 1 in my building ↑ 2 in the community	↑ 1	↑ 2	↑ 3
c. food bank?	↑ 0	↑ 1	↑ 1 in my building ↑ 2 in the community	↑ 1	↑ 2	↑ 3
d. municipal community or recreation centre?	↑ 0	↑ 1	↑ 1 in my building ↑ 2 in the community	↑ 1	↑ 2	↑ 3
e. mental health service?	↑ 0	↑ 1	↑ 1 in my building ↑ 2 in the community	↑ 1	↑ 2	↑ 3
f. health service?	↑ 0	↑ 1	↑ 1 in my building ↑ 2 in the community	↑ 1	↑ 2	↑ 3
g. addiction services	↑ 0	↑ 1	↑ 1 in my building ↑ 2 in the community	↑ 1	↑ 2	↑ 3
g. church, mosque or temple?	↑ 0	↑ 1	↑ 1 in my building ↑ 2 in the community	↑ 1	↑ 2	↑ 3
h. legal service?	↑ 0	↑ 1	↑ 1 in my building ↑ 2 in the community	↑ 1	↑ 2	↑ 3
i. advocacy service? (i.e. groups that speak on your behalf, or take action about issues relevant to you)	↑ 0	↑ 1	↑ 1 in my building ↑ 2 in the community	↑ 1	↑ 2	↑ 3

7.4 Have you felt guilty about your drinking?

1 0 No 1 1 Yes 1 77 don't know 1 88 not applicable

7.5 Have you used alcohol to steady the nerves or to reduce the effects of a hangover?

1 0 No 1 1 Yes 1 77 don't know 1 88 not applicable

7.6 At the present time, do you smoke (i.e cigarette, pipe tobacco, cigars) daily, occasionally, or not at all?

1 2 daily
1 1 occasionally
1 0 not at all → *(if not at all, skip to section 8.0)*
1 77 don't know
1 88 not applicable

7.6a How much do you smoke (approximate # of cigarettes, cigars or amount of pipe tobacco & interval: daily, weekly)? — —

8.0 Health Status

These questions ask for your views about your health. If you are unsure about an answer, please give the best answer you can.

8.1 In general, would you say your health is:

1 1 poor 1 4 very good
1 2 fair 1 5 excellent
1 3 good 1 77 don't know

8.2 The following questions are about activities you might do during a typical day. Does your health now limit you in these activities and if so, how much?

8.2a Moderate activities, such as walking to the corner store

1 0 No, not limited at all
1 1 Yes, limited a little
1 2 Yes, limited a lot
1 77 don't know
1 88 not applicable

8.2b Climbing several flights of stairs

- Í 0 No, not limited at all
- Í 1 Yes, limited a little
- Í 2 Yes, limited a lot
- Í 77 don't know
- Í 88 not applicable

8.3 During the past 4 weeks, have you had any of the following problems with your daily activities *as a result of your physical health*?

8.3a Accomplished less than you would like

- Í 0 No
- Í 1 Yes
- Í 77 don't know
- Í 88 not applicable

8.3b Were limited in the kind of activities

- Í 0 No
- Í 1 Yes
- Í 77 don't know
- Í 88 not applicable

8.4 During the past 4 weeks, have you had any of the following problems with regular daily activities *as a result of any emotional problems* (such as feeling depressed or anxious)?

8.4a Accomplished less than you would like

- Í 0 No
- Í 1 Yes
- Í 77 don't know
- Í 88 not applicable

8.4b Didn't do activities as carefully as usual

- Í 0 No
- Í 1 Yes
- Í 77 don't know
- Í 88 not applicable

8.5 During the past 4 weeks, how much did *pain* interfere with your daily activities?

- | | | | |
|-----|--------------|------|----------------|
| Í 0 | Not at all | Í 3 | Quite a bit |
| Í 1 | A little bit | Í 4 | Extremely |
| Í 2 | Moderately | Í 77 | don't know |
| | | Í 88 | not applicable |

- 8.6** These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks ...

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
8.6a. have you felt calm and peaceful?	1 0	1 1	1 2	1 3	1 4
8.6b. did you have a lot of energy?	1 0	1 1	1 2	1 3	1 4
8.6c. have you felt downhearted or depressed?	1 0	1 1	1 2	1 3	1 4
8.6d. have your physical health or emotional problems interfered with your social activities?	1 0	1 1	1 2	1 3	1 4

Next, we'd like to ask you some questions about your personal safety.

- 8.7** In the past six months, have you been robbed? 1 0 no 1 1 yes
- 8.8** In the past month, were you beaten up or physically attacked? 1 0 no 1 1 yes
- 8.9** In the past month, were you sexually assaulted? 1 0 no 1 1 yes
- 8.10** Do you feel safe here (*supportive housing*)? 1 0 no 1 1 yes
(if yes , skip to 9.1)

8.10a If no, why not? (*allow them to answer without using list*).

- 1 1 people that live in the building
- 1 2 younger people that live in the building
- 1 3 guests of people in the building
- 1 4 people that live near the building
- 1 5 criminal activity (*e.g. drug dealing, prostitution*)
- 1 6 no security
- 1 7 inadequate security
- 1 8 other (*please specify* _____)

9.0 Checklist of Health Problems

Now I'd like to ask about chronic conditions that you may have right now.

	9.1 Do you have....		9.2 How do you know you have this? i.e. who made the diagnosis				9.3 Is it being treated?	
	No	Yes	Doctor	Nurse	Self	Other	No	Yes
a. Migraine headaches?	0	1	0	1	2	3	0	1
b. Epilepsy?	0	1	0	1	2	3	0	1
c. Trouble with your vision?	0	1	0	1	2	3	0	1
d. Trouble with your hearing?	0	1	0	1	2	3	0	1
e. Trouble with your teeth or gums?	0	1	0	1	2	3	0	1
f. Back problems, but not arthritis?	0	1	0	1	2	3	0	1
g. Arthritis or rheumatism?	0	1	0	1	2	3	0	1
h. Chronic bronchitis or emphysema?	0	1	0	1	2	3	0	1
i. Trouble with blood in your stool?	0	1	0	1	2	3	0	1
j. Trouble with vomiting of blood?	0	1	0	1	2	3	0	1
k. Skin ailments?	0	1	0	1	2	3	0	1
l. Foot sores?	0	1	0	1	2	3	0	1
m. Diarrhea?	0	1	0	1	2	3	0	1
n. Trouble controlling your bladder?	0	1	0	1	2	3	0	1
o. Stomach or intestinal ulcers?	0	1	0	1	2	3	0	1
p. Effects of stroke?	0	1	0	1	2	3	0	1
q. Cirrhosis of the liver (liver failure)	0	1	0	1	2	3	0	1
r. A heart attack?	0	1	0	1	2	3	0	1
s. Trouble with your heart (other than heart attack)?	0	1	0	1	2	3	0	1
t. High blood pressure?	0	1	0	1	2	3	0	1
u. Diabetes?	0	1	0	1	2	3	0	1
v. Asthma?	0	1	0	1	2	3	0	1
w. Schizophrenia?	0	1	0	1	2	3	0	1
x. Trouble with depression?	0	1	0	1	2	3	0	1
y. Extreme Mood Swings (bipolar)?	0	1	0	1	2	3	0	1
z. Trouble with your nerves or anxiety?	0	1	0	1	2	3	0	1

Chronic Conditions Continued

9.1 Do you have....

9.2 How do you know you have this? i.e. who made the diagnosis

9.3 Is it being treated?

	No	Yes	Doctor	Nurse	Self	Other	No	Yes
aa. Cancer?	0	1	0	1	2	3	0	1
If yes, which type? _____								
bb. Tuberculosis?	0	1	0	1	2	3	0	1
cc. Obesity?	0	1	0	1	2	3	0	1
dd. Breathing problems?	0	1	0	1	2	3	0	1
ee. Alzheimer's disease or other dementia?	0	1	0	1	2	3	0	1
ff. Parkinson's disease	0	1	0	1	2	3	0	1
gg. Hepatitis	0	1	0	1	2	3	0	1
hh. Other (<i>specify</i> _____)	0	1	0	1	2	3	0	1

Now I will ask about any injuries, which occurred in the past 6 months, that were serious enough to limit your normal daily activities (e.g., a broken bone, a bad cut or burn, a sore back or sprained ankle).

9.4 In the past 6 months, did you have any injuries that were serious enough to limit your normal activities?

1 0 no 1 1 yes 1 77 don't know

9.4a If yes, how many times were you injured? ____ ____ ____ (*enter number of times*)

9.5 How did it happen (if more than one injury occurred describe the most serious occurrence)?
For example, was the injury due to a fall, a fight etc. (do not read list, mark one only)

- | | |
|--|---|
| 1 1 hit by a car | 1 6 suicide attempt |
| 1 2 accidental fall | 1 7 natural factors, e.g., weather , poison ivy, animal bites, stings |
| 1 3 fire, flames, or resulting fumes | 1 8 cutting or piercing objects, e.g. knife, stapler |
| 1 4 accidentally struck by an object or person | 1 9 poisoning |
| 1 5 physical assault | 1 10 other (<i>specify</i>) _____ |
| | 1 77 don't know |

10.0 Orientation-Memory-Concentration

Now, I'll ask you a few questions that assess your memory and ability to concentrate. (*check off ALL correct responses and note any partially correct answers or failures*)

10.1 What year is it now? ____ ____ ____ ____ (*enter year*)

10.2 What month is it now? _____ (*enter month*)

10.2a Could you please repeat this phase:

Toronto participants: John Brown, 42 Market Street, Toronto

Calgary participants: John Brown, 42 Market Street, Calgary

10.3 About what time is it? (within one hour) _____ (enter answer)
(interviewer to record actual time) _____ (enter real time)

10.4 Count backwards 20 to 1 _____ (record)

10.5 Say the months in reverse order _____ (record)

10.6 Ask the participant to recall the phrase they repeated in 10.2a

_____ (part of phrase repeated)

11.0 Activities of Daily Living

I will read out some everyday activities. Please tell me whether you are able to do each of them by yourself, with some help, or not at all.

	No Help 1 0	Help 1 1	Unable to do 1 2
11.1 Walking across a small room?	1 0	1 1	1 2
11.2 Bathing, either a sponge bath, tub bath or a shower?	1 0	1 1	1 2
11.3 Personal grooming, like brushing your hair, brushing your teeth, or washing your face?	1 0	1 1	1 2
11.4 Dressing, like putting on a shirt, buttoning and zipping, or putting on shoes?	1 0	1 1	1 2
11.5 Eating or drinking?	1 0	1 1	1 2
11.6 Getting from a bed to a chair?	1 0	1 1	1 2
11.7 Using a toilet?	1 0	1 1	1 2

12.0 Mood

Now I will ask you a few questions about how you are feeling these days. Choose the best answer for how you have felt over the past week.

	No	Yes
12.1 Are you basically satisfied with your life?	1 0	1 1
12.2 Have you dropped many of your activities and interests?	1 0	1 1
12.3 Do you feel that your life is empty?	1 0	1 1
12.4 Do you often get bored?	1 0	1 1
12.5 Are you in good spirits most of the time?	1 0	1 1
12.6 Are you afraid that something bad is going to happen to you?	1 0	1 1
12.7 Do you feel happy most of the time?	1 0	1 1
12.8 Do you often feel helpless?	1 0	1 1
12.9 Do you prefer to stay inside, rather than going out and doing new things?	1 0	1 1
12.10 Do you feel you have more problems with memory than most?	1 0	1 1
12.11 Do you think it is wonderful to be alive now?	1 0	1 1
12.12 Do you feel pretty worthless the way you are now?	1 0	1 1
12.13 Do you feel full of energy?	1 0	1 1
12.14 Do you feel that your situation is hopeless?	1 0	1 1
12.15 Do you think that most people are better off than you are?	1 0	1 1

13.0 Family

The next questions are about your family.

Do you have...

13.1a a current spouse/ partner? 1 0 no 1 1 yes	13.1b If yes, how many? n/a	13.1c If yes, have you had contact in the previous month? 1 0 no 1 1 yes	13.1d If yes, how many times? 1 1 once 1 2 twice 1 3 three or more times
13.2a ex-spouses/ partners? 1 0 no 1 1 yes	13.2b If yes, how many? _____	13.2c If yes, have you had contact in the previous month? 1 0 no 1 1 yes	13.2d If yes, how many times? 1 1 once 1 2 twice 1 3 three or more times
13.3a children? 1 0 no 1 1 yes	13.3b If yes, how many? _____	13.3c If yes, have you had contact in the previous month? 1 0 no 1 1 yes	13.3d If yes, how many times? 1 1 once 1 2 twice 1 3 three or more times
13.4a brothers or sisters? 1 0 no 1 1 yes	13.4b If yes, how many? _____	13.4c If yes, have you had contact in the previous month? 1 0 no 1 1 yes	13.4d If yes, how many times? 1 1 once 1 2 twice 1 3 three or more times
13.5a in-laws (<i>ex in- laws</i>)? 1 0 no 1 1 yes	13.5b If yes, how many? _____	13.5c If yes, have you had contact in the previous month? 1 0 no 1 1 yes	13.5d If yes, how many times? 1 1 once 1 2 twice 1 3 three or more times
13.6a grandchildren? 1 0 no 1 1 yes	13.6b If yes, how many? _____	13.6c If yes, have you had contact in the previous month? 1 0 no 1 1 yes	13.6d If yes, how many times? 1 1 once 1 2 twice 1 3 three or more times
13.7a other family? 1 0 no 1 1 yes	13.7b If yes, how many? _____	13.7c If yes, have you had contact in the previous month? 1 0 no 1 1 yes	13.7d If yes, how many times? 1 1 once 1 2 twice 1 3 three or more times

14.0 Social Support

Now I would like to ask a few questions about the quality and nature of your social ties with family, friends and neighbours.

Considering the people to whom you are related either by birth or marriage...

14.1 How many relatives do you see or hear from at least once a month?

1 0 none 1 1 one 1 2 two 1 3 three or four 1 4 five thru eight 1 5 = nine or more
1 77 don't know 1 88 not applicable

14.2 How many relatives do you feel at ease with that you can talk about private matters?

1 0 none 1 1 one 1 2 two 1 3 three or four 1 4 five thru eight 1 5 = nine or more
1 77 don't know 1 88 not applicable

14.3 How many relatives do you feel close to such that you could call on them for help?

1 0 none 1 1 one 1 2 two 1 3 three or four 1 4 five thru eight 1 5 = nine or more
1 77 don't know 1 88 not applicable

Considering all of your friends including those who live in your neighborhood....

14.4 How many of your friends do you see or hear from at least once a month?

1 0 none 1 1 one 1 2 two 1 3 three or four 1 4 five thru eight 1 5 = nine or more
1 77 don't know 1 88 not applicable

14.5 How many friends do you feel at ease with that you can talk about private matters?

1 0 none 1 1 one 1 2 two 1 3 three or four 1 4 five thru eight 1 5 = nine or more
1 77 don't know 1 88 not applicable

14.6 How many friends do you feel close to such that you could call on them for help?

1 0 none 1 1 one 1 2 two 1 3 three or four 1 4 five thru eight 1 5 = nine or more
1 77 don't know 1 88 not applicable

Considering friends, neighbours, family and service providers...

14.7 During the last month have you had any unpleasant disagreements/interactions that made you feel angry or upset ?

1 0 no (if not skip to 14.8) 1 1 yes

14.8 If yes, with who?

1 1 family 1 2 friend 1 3 resident/tenant 1 4 service provider

14.8 When you need help who helps you the most?

1 1 family 1 2 friend 1 3 resident/tenant 1 4 service provider

15.0 Social Isolation

The next questions are about how you feel about different aspects of your life. For each one, tell me how often you feel that way.

15.1 How often do you feel that you lack companionship?

1 1 hardly ever 1 2 some of the time 1 3 often

15.2 How often do you feel left out?

Í 1	Í 2	Í 3
hardly ever	some of the time	often

15.3 How often do you feel isolated from others?

Í 1	Í 2	Í 3
hardly ever	some of the time	often

16.0 Life Satisfaction

16.1 Please indicate whether you strongly disagree, disagree, neither agree nor disagree, agree or strongly agree with the following statement

I am satisfied with my life.

Í 1	Í 2	Í 3	Í 4	Í 5
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

17.0 Income

17.1 What best describes your employment status during the past six months?

Í 1	full-time job (more than 24 hours per week)
Í 2	part-time job
Í 3	casual work
Í 4	self-employed
Í 5	unemployed and looking for work
Í 6	unemployed and not looking for work
Í 7	unemployed because of disability
Í 8	retired
Í 9	other (<i>specify</i> _____)

17.2 Did you receive money from any of the following sources in the last month?

	No	Yes
a. employment (wages)	1 0	1 1
b. Employment Insurance	1 0	1 1
c. Workers' Compensation	1 0	1 1
d. pension from previous employer (private pension)	1 0	1 1
e. survivor's benefit from spouse's private/occupational pension	1 0	1 1
f. Canada Pension Plan (CPP) - retirements benefits	1 0	1 1
g. Canada Pension Plan (CPP) - survivor's benefits	1 0	1 1
h. Canada Pension Plan (CPP) - disability benefits	1 0	1 1
i. Old Age Security (OAS)	1 0	1 1
j. Guaranteed Income Supplement (GIS)	1 0	1 1
k. early retirement incentive package	1 0	1 1
l. Personal Needs Allowance	1 0	1 1
o. Retirement Income Fund (RRIF)	1 0	1 1
p. savings	1 0	1 1
q. family or friends	1 0	1 1
r. alimony from ex-spouse	1 0	1 1
s. child support	1 0	1 1
t. pension from foreign country of origin	1 0	1 1
u. panhandling	1 0	1 1
v. other (<i>Specify:</i> _____)	1 0	1 1
<i>Ontario Residents:</i>		
aa. Ontario Works [OW](general welfare assistance)	1 0	1 1
bb. Ontario Disability Support Program [ODSP]	1 0	1 1
<i>Alberta Residents:</i>		
cc. Alberta Seniors Benefit Program	1 0	1 1
dd. Special Needs Assistance for Seniors	1 0	1 1
ee. Alberta Widow's Program	1 0	1 1
ff. Assured Income for the Severely Handicapped [AISH]	1 0	1 1
gg. Supports for Independence [SFI]	1 0	1 1

17.3 Which income group listed below best describes how much money you received in 2004 from all sources (as selected in question 17.2)?

- | | |
|----|---------------------|
| 1 | Under \$2000 |
| 2 | \$ 2,000 - \$ 4,999 |
| 3 | \$ 5,000 - \$ 6,999 |
| 4 | \$ 7,000 - \$ 9,999 |
| 5 | \$10,000 - \$11,999 |
| 6 | \$12,000 - \$14,999 |
| 7 | \$15,000 - \$19,999 |
| 8 | \$20,000 - \$24,999 |
| 9 | \$25,000 - \$29,999 |
| 10 | \$30,000 - \$34,999 |
| 11 | \$35,000 - \$39,999 |
| 12 | \$40,000 - \$44,999 |
| 13 | \$45,000 - \$49,999 |
| 14 | \$50,000 - \$59,999 |
| 15 | \$60,000 - \$74,999 |
| 16 | \$75,000 and over |

17.4 Please tell me (to the nearest hundred dollars) how much money you received from all sources in the last month?

_____ (enter income from all sources)

17.5 Do you have a “Substitute Decision Maker,” “Public Trustee” or “Power of Attorney” that manages your money for you?

(if no “manage
question 17.6)

from family, friends

- | | |
|----|---|
| 0 | no, I manage my money myself
<i>myself”, skip to</i> |
| 1 | no, but I do have informal help i.e.
or staff |
| 2 | yes |
| 77 | don’t know |
| 88 | not applicable |

17.5a If yes, do you find this helpful?

- | | |
|----|---------------------------|
| 1 | very helpful |
| 2 | somewhat helpful |
| 3 | somewhat <i>unhelpful</i> |
| 4 | very <i>unhelpful</i> |
| 77 | don’t know |
| 88 | not applicable |

17.6 Do you give any of your income to family or friends?

- 1 0 no (*if no, skip to 17.7*)
- 1 1 yes
- 1 77 don't know
- 1 88 not applicable

17.6a If Yes, is it on a voluntary basis?

- 1 0 no
- 1 1 yes
- 1 77 don't know
- 1 88 not applicable

17.7 Did you receive any money from family or friends in the last six months?

- 1 0 no (*if no, skip to 17.8*)
- 1 1 yes
- 1 77 don't know
- 1 88 not applicable

17.7a If Yes, who did you receive money from (i.e. sister, brother, child, friend)?

17.7b How often did you receive money? _____

17.7c How long have you been receiving money from (*insert global category e.g brother, friend*)

____ (enter length of time)

17.8 How adequate do you feel that your current income is in meeting your daily needs?

- | | | | |
|---------------|----------|------------|-----------------|
| 1 1 | 1 2 | 1 3 | 1 4 |
| Very adequate | Adequate | Inadequate | Very inadequate |

THANK YOU FOR YOUR TIME!

Notes (either on the interview process or comments by participants):

[illegible]

APPENDIX D – LIST OF COMMUNITY ORGANIZATIONS

Calgary Agencies

1. Alberta Seniors and Community Supports
2. Baker House
3. The Alex Community Health Centre
4. Calgary Health Region
5. Calgary Housing Company
6. Canadian Mental Health
7. Calgary Urban Project Society (CUPS)
8. The Dream Centre
9. Edwards Place
10. Glamorgan Care Centre
11. The Kerby Centre
12. MCF Housing for Seniors
13. The Mustard Seed
14. Peter Coyle Place
15. The Salvation Army Booth Centre
16. The Salvation Army Centre of Hope
17. Seniors Services Division – City of Calgary
18. Trinity Place Foundation of Alberta

Toronto Agencies

1. ABI Possibilities
2. Bill McMurray Residence
3. City of Toronto
4. CMHA York Region
5. Community Care Access Centres
6. Daily Bread Food Bank
7. Davenport Perth Neighbourhood Centre
8. Dixon Hall
9. East York Access Centre for Community Services
10. Ecuhome
11. Etobicoke Services for Seniors
12. Evangel Hall
13. Fred Victor
14. Good Neighbour Club
15. Good Shepherd Ministries
16. Habitat Services



17. Homes First Society
18. House of Compassion of Toronto
19. Houselink
20. John Gibson House
21. Joubert House
22. Loft - Collegeview
23. Loft - St. Anne's
24. Mainstay Housing
25. Meegwetch
26. Na Me Res
27. North York Harvest
28. Parkdale Activity Recreation Centre (PARC)
29. Parkdale Community Information Centre
30. Pears Avenue Housing Project
31. Portland Place
32. Progress Place
33. Providence Centre
34. Regeneration House
35. Regent Community Health Centre
36. Senior Link
37. Sistering
38. South Riverdale Woods Community Centre
39. South Simcoe Community Information Centre
40. SPRINT
41. St. Christopher's House
42. St. Jude Community Homes
43. St. Stephen's
44. Storefront Humber
45. Storefront Scarborough
46. Street Haven
47. Street Health
48. Toronto Christian Resource Centre
49. Toronto Community Housing Corporation
50. Woodgreen Community Centre

